ASSESSING THE EFFECTIVENESS OF FEDERAL ASSISTANCE PROGRAMS IN RURAL MISSISSIPPI

HEARING

BEFORE THE

SELECT COMMITTEE ON HUNGER
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

HEARING HELD IN ITTA BENA, MS,
JULY 24, 1987

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ASSESSING THE EFFECTIVENESS OF FEDERAL ASSISTANCE PROGRAMS IN RURAL MISSISSIPPI

FRIDAY, JULY 24, 1987

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON HUNGER,
Itta Bena, MS.

The select committee met, pursuant to notice, at 12:30 p.m., Social Sciences Building Auditorium, Mississippi Valley State University, Hon. Mickey Leland (chairman of the committee) presiding.

Members present: Representatives Kostmayer, Penny, Espy, Flake, and Mfume.

Chairman LELAND. Let us now open our hearing.

Before I make my opening statement as the Chair of the House Select Committee on Hunger, let me recognize a person about whom we are all very excited. We are all, I am sure, very happy that you have him sent to Washington to represent your interests. He is a person who has become a very good and personal friend; you can tell the manifestation of that friendship by the fact that the House Select Committee on Hunger is here today. The person of whom I speak is the Honorable Mike Espy from Yazoo City, MS. [Applause.]

OPENING STATEMENT OF HON. MIKE ESPY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. ESPY. Thank you, Mr. Chairman.

I have a prepared statement, but I realize that the time is short, and I do not want to burden the committee by reading it. So, I would ask unanimous consent to enter this into the record.

Chairman LELAND. Without objection.

Mr. ESPY. Thank you, sir.

I do have a couple of personal observations I would like to make, and I will be brief.

I would like to welcome the chairman, Congressman Mickey Leland from Texas, to Mississippi and to the second district of Mississippi, and I would like to welcome all the members on the Select Committee on Hunger to Mississippi.

We have to stop and thank all of the citizens for taking time out to come today to share rural concerns about an issue which continues to plague our country, the issue of hunger.

We appreciate all the witnesses that will appear here today. We thank all of you that have interrupted your schedules and delayed personal matters to share your opinion on the effectiveness of

public assistance programs here in Mississippi as well as across rural America because, Mr. Chairman, although we are here in Itta Bena, although we are here in Mississippi, we are just not going to talk about programs in Mississippi and problems of Mississippi. We are talking, in effect, about rural America, rural communities all over this great country.

In 1984, the Select Committee on Hunger traveled to Mississippi. I was not privileged to have been at that time a Member of Congress, but you traveled to Mississippi to gather information on how well the residents were being served by antihunger programs, such as food stamp and WIC, and we are back to see if things have changed, to see if they have gotten better, to see if they have gotten worse.

If I can offer a basic comment toward that end, I would say honestly that Mississippi's story is neither all good nor all bad.

There have been some significant progress since you last came here. Mr. Chairman, with the committee, and I want to single out two areas of progress. One is relative to the decrease in infant mortality rates and the other is with respect to the Medicaid eligibility requirements.

In Washington a couple of weeks ago, I was pleased to pick up a magazine, a Washington, D.C., magazine, and the cover was entitled, "What the District of Columbia Can Learn From Mississippi," and the story was about how the infant mortality rate had decreased. In fact, Washington, D.C., right now has the unfortunate distinction of having the highest rate of infant mortality in this country.

Since you last came to Mississippi, the infant mortality rate has decreased from 14.4 per thousand births in 1984 to a current rate of 12.3 per live births. This is largely being done because of dedicated health professionals, some of whom you will hear from today, but dedicated health professionals that have conducted active campaigns in preventing unplanned pregnancies, talking to people about prenatal care, and preventive health services.

Now, with respect to Medicaid eligibility requirements. Mississippi is among the States that have elected to implement new Medicaid eligibility requirements which, as you know, Mr. Chairman, have been allowed under the Omnibus Budget Reconciliation Act. Effective October 1987, Mississippi will raise its needs standard for pregnant women and children under 1, thereby extending Medicaid coverage to over 12,000 new women and children that previously, have not been allowed to participate in that program.

Although we have made some gains, every one in this auditorium certainly realizes that we cannot be content with what we have done, with what we have been able to achieve, because hunger still exists in Mississippi and it still exists at a level which requires our continued support of food assistance programs.

This morning we visited the communities of Rome and Marks, and saw things that I think are pretty bad. The one that remains and smacks you in the face involves the substandard living conditions of the people.

But that is really not unusual in some rural communities in Mississippi and rural communities all over America. In fact, the 1980 Census says that one-fifth of all of our housing continues to be sub-

standard and dilapidated. If we can continue talking statistically, in Mississippi, we have 13.8 percent unemployment statewide. In Angel Grove, one of the communities that I represent, Mr. Chairman, the unemployment rate is about 44 percent. Forty-five percent of folks in Mississippi still do not have a high school diploma, still too many live below the poverty level, as evidenced right here in Leflore County, where 27 percent of the population is below the poverty level.

In closing, I am pleased to have invited you here. I am pleased that you honored me and honored us by asking the committee to come, and I would just like to repeat that even though we are here at Mississippi Valley State University and even though we are here in Itta Bena, we will hear about problems in Mississippi, but it is symptomatic of problems all over this country.

Thank you for honoring me and thank you for honoring us by coming.

[The prepared statement of Mr. Espy appears at the conclusion of the hearing, see p. 75.]

OPENING STATEMENT OF HON. MICKEY LELAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Chairman LELAND. Thank you very much, Mike.

Let me say to all of you that it is rather unusual to have this many members present at a field hearing. It is very difficult for me as chairman of this committee as well as many other Chairs of other committees of Congress to get so many people to travel this far. We left Washington, after having departed an hour late. Our flight was diverted from landing in Memphis and went on to Nashville. We stayed there for awhile to refuel, traveled to Memphis, and drove to Greenwood because we had missed the connection going into Greenville.

I would like to thank Congressman Espy again for inviting the select committee back to Mississippi to reassess the impact of Federal assistance programs in alleviating the hardships of hunger and poverty among low-income Mississippians.

In 1984, the select committee visited Greenwood to examine the accessibility of Federal food and income security services to low-income residents of this State and the effectiveness of these programs in helping participants achieve the highest quality of life.

When we were here before, the State had the highest infant mortality rate in the Nation. We found a vast number of poor people were failing to receive benefits to which they were, indeed, entitled. We spoke with families who were forced to choose between having a decent diet and having a roof over their heads.

Since that visit, a number of changes have occurred, as Mike has indicated. The State has approved programs to aid those living in poverty and Federal legislation revising the food stamp and Aid to Families with Dependent Children, the AFDC Program, and a host of other major assistance programs have been enacted.

The select committee is here today to see what impact these policy and programmatic changes have had on the life-styles of the poor and what additional actions we must take to improve their quality of life.

As Mike has indicated, too, while things have gotten a little bit better, we still have a long way to go.

There are a number of distinguished witnesses who will discuss the achievements that have been made in Mississippi and provide us with some guidance as to what additional battles must be waged to vanquish hunger and poverty in the Delta.

Representative Espy, during his brief tenure in Congress, has, indeed, been extremely active in efforts to reduce the deplorable conditions that poverty imposes not only on poor people in Mississippi but on poor Americans across the Nation. Through his work as a member of the House Agriculture and House Budget Committees, and, as the only freshman member on the House Budget Committee, Mr. Espy has already become quite influential in his first few months in Congress.

He has also shown exemplary leadership as a member of the Select Committee on Hunger, and he has worked diligently to assure an improved quality of life for impoverished Americans around this country.

His service on the Agriculture Committee, by the way, is very much welcomed by the Congressional Black Caucus because he is the first black Member of Congress to serve on the Agriculture Committee. [Applause.]

He brings to Congress a different perspective. He comes from a rural community, and we depend on a lot on his advice and wisdom about what we should do in chartering the course not only for black America and the Congressional Black Caucus, but for rural America in general.

He has taught me about catfish farming. I never knew anything about it. All I knew is I liked it. He even brought some catfish farmers to Washington so that we could all enjoy the great fruits of the labors of the catfish farmers. He also teaches us about the plight of the family farmers in Mississippi and those of you who benefit from that industry.

Let me, for now stop giving plaudits to Mike Espy. We have other Members of Congress who are present—some who have served longer or just as long as I, Pete Kostmayer from Pennsylvania and Tim Penny from Minnesota, and others who have just arrived to Congress. We also have two of our freshmen colleagues, who are here with Mike in solidarity to show their support for his work in Congress—Kweisi Mfume and Floyd Flake.

Congressman Mfume is from Baltimore and Congressman Flake is from New York. I would like to note that he was born and reared in Houston, TX. At the time, he lived in a black community called Acreage Homes. As a matter of fact, when I got to Congress, that part of the city was not even in my district, and I decided that those people needed some real good representation. So, after redistricting, I brought them into my district, and all of his family live in my district. So, I treat him especially well as a member of this committee.

But let me now stop my monologue and say to all of you, and I say this very sincerely, I have developed a very keen and a very deep and abiding understanding and respect and love for the people, particularly of the Mississippi Delta, but of Mississippi in general. I have been to this area. I was here just visiting with my

wife just a few weeks ago, but, of course, again, we have indicated, I was here a few years ago with the Select Committee on Hunger.

We want to do what we can to help. That is why we hold field hearings around the country. I cannot promise that things are going to change overnight. The nature of our involvement in politics and in government is such that we go out among the American people to find out what it is that they really need for a wholesome and healthy life to make sure that the fiber of this country is strong, and, indeed, we have found many, many problems.

We are suffering from budget deficits. We have an increasing problem with frictions between our Nation and the Soviet Union on how we are going to resolve the nuclear armament question. Population is exploding in the world.

We have all of these problems that we are attendant to, and we recognize that it is most important that we make sure that the people of America are strong and viable. We do not want to raise your expectations unrealistically. Things are not going to happen overnight. We are going to do what we can. We can take back to Congress what we saw and heard, both here, and what we saw in the field today when we went to Rome. We will inform our colleagues who are not with us of the horror of circumstances that we have witnessed here in the Mississippi Delta.

We recognize that there are persons who are well off here, that things are getting better, but we also know of the extreme poverty of this State. We want to do what we can.

Now, let me turn to my colleague, who, in a sense, is senior to me, and who is very devoted to the issue of alleviating hunger, not only in this country but in the world. He and I have traveled to Ethiopia and to other places both here and abroad together. I have a great deal of respect and admiration for him—Pete Kostmayer from the State of Pennsylvania.

The gentleman from Pennsylvania.

[The prepared statement of Mr. Leland appears at the conclusion of the hearing, see p. 77.]

OPENING STATEMENT OF HON. PETER H. KOSTMAYER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. KOSTMAYER. Well, thank you, Mr. Chairman, very much.

Ladies and gentlemen, just very briefly, it is nice to be here and it is nice to be in the State of Mississippi, although the people who run the airlines tried to keep us from getting here. They tried to kidnap us and take us up to Nashville, TN, but we escaped, and we got down here, and we are very glad to be here, and I think as Congressman Espy said and as Congressman Leland said, Mississippi is a State very much like the rest of America, except that you have maybe better food here.

We had a delicious lunch and enjoyed it. We are here to look at the problems of Mississippi. We have many of the same kinds of problems that you have where I come from in Philadelphia. We are certainly not here to make any harsh judgments or to be critical, but we have been invited here, and we are glad to be here, and that is really all I want to say, except that it is a pleasure to be

here with your Congressman, Congressman Espy, who I want you to know, and, you know, we politicians never say anything that is not true, I want you to know that, seriously, he is becoming known, although he is a new Member of Congress, as one of the most serious Members of Congress and one of the most effective Members of Congress and one of the hardest working Members of Congress.

The real reason that I have come to Mississippi is to find out how Espy got himself on the Budget Committee because I have been trying for 10 years to get on the Budget Committee. He just showed up in Washington and he is already on the most important committee in the U.S. Congress, the Budget Committee, that gets to decide where to spend the money. [Applause.]

And I think that all of us are hoping that he will give us a little money and not give it all to you, but it is a pleasure to be here and it is a pleasure to be here with Congressman Espy, especially.

Chairman LELAND. Thank you, Pete.

Let me now introduce our colleague from Baltimore, MD. Everybody has a problem with pronouncing his name, and I always ask him to tell me what his name used to be so I can have a better time of it, but that is the best-kept secret of America.

Kweisi Mfume has, like Mike, established a reputation for diligence and industry in the Congress of the United States, and he, too, is moving into great leadership opportunities. I am glad that he was able to be here.

Kweisi Mfume from Baltimore, MD.

OPENING STATEMENT OF HON. KWEISI MFUME, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. MFUME. Thank you very much, Mr. Chairman.

Actually, it is not that hard at all. It is pronounced Kweisi Mfume, but the chairman is undergoing a phonetic pronunciation lesson, and we hope to have him down packed with my name very shortly.

I want to extend my thanks to the chairman, who has the foresight to conduct this committee in such a way that it really does all that it is supposed to do regarding hunger, both nationally and world-wide, and I thank him very much for extending the opportunity for me as a member of this committee to be with you here today.

I want to add on, if I might, just a moment, to something that my colleague from Pennsylvania, Pete Kostmayer, just said about your food. It is good food, and they laughed at me in the restaurant because I ate so much of it, but I would hope that somewhere along the line between here and the time we go, Mr. Chairman, that I could have some more of this food, so I could talk about it when I get back home.

Let me say that Mike Espy is right. This area and the problems that you have here are not that dissimilar from problems elsewhere around the Nation. Hunger is a very, very serious problem. Poverty, as you know, is a serious problem. And we are here really to ascertain as best we can how it is affecting this region and how the Congress of the United States, legislatively and otherwise, might be able to do something about it.

I would be remiss, however, if I did not say, as my colleagues have said, that you are blessed in this region to have someone like Mike Espy to represent you. He is a great Congressman already. He is a stalwart in the storm. One who stands steady and steadfast through it all and no matter how long the journey, cold the chill, fierce the enemy or few the friends, he was the one who captured your will to be different and your will to dare to make a difference, and he is doing that same thing in Washington, and I say that as a freshman colleague and as one who is honored to serve with him, both on this committee and in the 100th Congress of the United States.

Hunger, as we all know, has no color, pain has no limit, and when a baby cries at night, it does not cry in black or white, it cries in hunger. This is not a perfect Nation and we are not perfect people, but God still calls us to a perfect mission.

It is a mission to feed the hungry, to clothe the naked, to house the homeless, to teach the illiterate, to provide guidance for our young and security for our seniors, and although we do not have sovereign territories, we do have a sovereign and sober responsibility, and, so, I hope that this committee leaves this great State with a better understanding of what we must do and how we must do it regarding the situation of hunger and poverty, not only in Mississippi but across these United States, and I am honored, deeply honored, to be your guest here today.

Thank you very much.

Chairman LELAND. Thank you. [Applause.]

Thank you, Kweisi.

Let me turn now to the gentleman from Minnesota, with whom I have also traveled around the country. I have learned recently by working with him of his great sensitivity for human beings.

We were recently in North Dakota visiting an Indian reservation, and just hearing him reflect on the problems there evoked from me a great deal of respect for him.

I have been in Congress now for 9 years. So, I am getting to be old hat, but these younger guys are really feisty, industrious and incredible human beings.

So, let me now turn to my good friend, Tim Penny.

OPENING STATEMENT OF HON. TIMOTHY J. PENNY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. PENNY. Thank you, Mr. Chairman.

I am now in my third term in Congress, elected from Southeastern Minnesota. There are some things that Minnesota has in common with Mississippi.

First of all, the river and, second, the soil. You have good farm land here in your part of the State because it washed down the river from my part of Minnesota. So, we have that in common, and we can produce very large quantities of grain on the soil up in Minnesota, and you have down here a combination of crops that you can grow in abundance.

The reason I am on the Hunger Committee is because it has always baffled me that here in our country, we can have bins literally bursting with surplus grain while, in so many areas around

the globe, bellies burst from starvation, and it just does not make sense to me. As an agricultural State legislator, I thought serving on the Hunger Committee would be an appropriate way to bring my ideas to bear on the problem of hunger.

But we differ a lot from you here in this part of Mississippi up in my part of Minnesota because while unemployment is quite high and poverty is very evident in many of your communities, unemployment in Minnesota is about 5 percent, and while we have low-income populations, the numbers are not so great, and there are no people in Minnesota or virtually none, at least in my part of the State, who, while they may be on public assistance and unemployed, live in the kinds of conditions that I witnessed this morning up in Tutwiler and Rome. And in talking with Dr. Brooks and your Congressman Espy, it is clear to me that in many of your smaller communities throughout this part of the State, that life style is common and that those homes are about the best homes that many people can find to live in, and, so, it has been an eye-opener for me.

I cannot, as the chairman cannot, tell you that by being here, we will immediately bring a change to this kind of existence overnight. But, clearly, more Members of Congress, from districts where these problems are not evident, need to come to parts of the Nation where they are, so we can learn more and bring that knowledge to bear on the issue. And, so, that is why I am here and I look forward to hearing your testimony.

Chairman LELAND. The next person I would like to introduce is a minister and a very successful politician, obviously, by the manifestation of his presence here today. He, too, has made a name for himself already in the Congress, and we are very proud of that. He is a very eloquent spokesperson on behalf of the people of his district, but also on behalf of hungry people in the world.

We in Congress have grown to know and respect him very much. I would like to point out that he also knows a little bit about this area or this region of the country because his family spends a lot of time in Memphis, TN.

So, let me now, without any procrastination on my part, introduce to you Rev. Floyd Flake. [Applause.]

OPENING STATEMENT OF HON. FLOYD H. FLAKE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. FLAKE. Thank you very much, Mr. Chairman, and certainly I am pleased to echo my concerns for being here, sharing with my colleagues, perhaps the only Member of the U.S. Congress to ever take catfish to London and France and require dignitaries of state in those two countries to eat catfish. I was with Mike a few weeks ago over there, and I will tell you as a witness that I saw it happen. I think you ordered how many tons and will be sending some more over there.

Mr. ESPY. 500 tons.

Mr. FLAKE. Yes. The people tasted it and even though they expressed it in their dialect, their language, we knew that they were tasting a delicacy and they responded so appropriately that you will be the benefactors in that you will have new shipments being sent to them.

I am happy to be here, Mike, to be a part of this Mississippi group. Not only, Mickey, are my folks from Memphis, but they moved from Water Valley and Grenada. Oh, see, somebody knows about that. Water Valley, MS, to Memphis. So, they come from the soil of Mississippi, and I am happy to be here.

Now, when I came to Congress back in January, Kweisi Mfume did not know one Scripture, but since I have been working with him, he stole my "providing for the homeless and food for the hungry" and all the rest of it.

So, I want to focus on a major crisis in America. There are too many who are a part of government who do not realize that hunger is, indeed, a problem for many of the citizenry. There are too many who really have not come to understand that there are those who suffer each and every day of their lives, who go to bed without the knowledge of where their next meal is coming from. Therefore, I am pleased that we are here to have this hearing, to share in other hearings that we have had and will be having, so that we might be able to bring attention to this problem that is confronting us today.

So many issues get focused on right now with the hearings that are going on in Washington and my district, where we talk primarily about drug issues. This issue has a way of kind of moving to the back burner. I think our presence here says that we do not think that this is a back burner issue, that the people are suffering every day, and that the Nation needs to be concerned about it.

We are here to do our part in trying to address it, and I thank you for the opportunity of being able to share in this hearing.

Chairman LELAND. Thank you, Congressman Flake.

Let me say that we are very happy to——

Mr. ESPY. Will the gentleman yield?

Chairman LELAND. Oh, sure.

Mr. ESPY. I just wanted to say I am up here basking in the glow of all these warm words. I just wonder if it is because I paid for us.

Chairman LELAND. OK. What is the name of the cafe?

Mr. ESPY. Booker's Cafe.

Chairman LELAND. Booker's Cafe is where we had lunch today, and let me recommend it to you. If you do not know where it is, you better find it. It is great.

But let me thank the president of Mississippi Valley State and those here who would allow us to come and hold this hearing in these great facilities. Mississippi Valley State is a great university, and I know that I was asked to come down to spend some time in your State capitol to try to encourage the State legislature as well as the Governor to support this great institution when they were talking about closing it down, and I was happy to have been here at that time. That was one of the other few times that I have been here and thank God it is still viable.

I want to thank the president. I understand Dr. Barnes is here to give a word of welcome to our colleagues here.

Dr. Barnes on behalf of Mississippi Valley.

STATEMENT OF JIMMY S. BARNES, ON BEHALF OF JOE L. BOYER, PRESIDENT, MISSISSIPPI VALLEY STATE UNIVERSITY

Mr. BARNES. Thank you, Mr. Chairman and the Members of the U.S. Congress, Select Committee on Hunger, especially to Congressman Mike Espy, our own Congressman, representing the proud people of district two in Mississippi. To the leaders of the community, this community, that toil in the vineyards every day giving service to the many people throughout this district and throughout this State.

Especially Ms. Joey Kraimer of Greenwood who has worked relentlessly in her efforts to relieve human suffering, and to the members of ROC Holmes County, I see some of them.

Ladies and gentlemen, I bring you greetings from our president, Dr. Joe L. Boyer, who has asked me to express his regrets for not being here at this time due to a commitment to the Alumni Association Convention in Memphis, TN.

I bring you greetings from the students, the faculty, administration, and staff of Mississippi Valley State University.

For those of you who are visiting us for the first time, I hope that some day you will come back here to share with us your dreams, your ideas about this particular country.

For those of you are visiting us—who have visited us before, welcome back. I hope that you, too, return to share with us your ideas.

Dr. Boyer has recently recommitted this university to share and to reach out to the community a helping hand or a helping ear, to listen to the types of problems that exist within this particular community. We—this was manifested in the authorization of the Center for Economic Development that we have on campus now, and, as a matter of fact, Dr. Young is directing the Economic Development Center to work with small farmers, businessmen, other entrepreneurs or would-be entrepreneurs.

In addition, Robert Moore, director of programs, the JOB Program, Juvenile Opportunity Bureau, which is a community-based alternative to incarceration of juvenile offenders in Indianola, MS, and Sunflower County.

So, these are the kinds of things that we are about, and we welcome you here. Mr. Chairman, we welcome you here because the destiny of Mississippi Valley is inextricably entwined in the destiny of the people of this district.

We welcome you because we know when it comes to your important matters that you are going to discuss here today, that the isles become narrow and they must, and because the politics is a poor dessert for a meal that a child or elderly person missed.

We hope that the insights that you will gain from your tour of this district and from your discussions you have here today will help you continue to provide the requisite resources, along with the guidelines and standards, for the many services that the people of this district and this great Nation need and deserve.

Again, welcome to the Mississippi Valley State University.

[The prepared statement of Mr. Barnes appears at the conclusion of the hearing, see p. 78.]

Chairman LELAND. Thank you very much. [Applause.]

Thank you very much.

Now, we will proceed with the official part of the hearing. I would like to call our first panel.

Let me now introduce them and ask them to summarize their prepared statements. We will, without any objection, offer your full statements for the record. That is not mandatory, but we would hope that you would be as brief as possible for the purpose of time so that we can get to the question and answer period and have all the questions answered that we might have of you.

Without any further delay, let me now introduce Mr. Chism, who came to the State government in 1985, is the deputy director of the Governor's Office of Federal-State Programs, and acting director of the Department of Human Development.

Mr. Louis Armstrong is the director of the Mississippi Legal Services Coalition, an organization with which he has been affiliated for the past 7 years. He also serves on the Jackson City Council, a position he has held since 1985.

Mr. Rims Barber is the project director for the Children's Defense Fund in Mississippi. He serves as the convener for the Mississippi Human Services Coalition and as chairman of the board for the State-Wide Food Bank.

Mr. Chism, you may proceed.

STATEMENT OF BRAD CHISM, INTERIM DIRECTOR, GOVERNOR'S OFFICE, FEDERAL-STATE PROGRAMS, MISSISSIPPI DEPARTMENT OF HUMAN DEVELOPMENT

Mr. CHISM. Thank you, Mr. Chairman.

Mr. Chairman, Congressman Espy and other distinguished members, I would like to welcome you on behalf of Gov. Bill Allain and Mr. Thigpen, the executive director of Federal-State programs.

I will attempt to be brief with these summary remarks. We are glad we have an opportunity to be here. We look forward to sharing with you our impressions of what some of the difficulties are of the Federal antipoverty programs.

We would like to say, first, that we realize there are a lot of things in State government in Mississippi that prevent the full and efficient operation of these programs. For example, within the executive branch of Government, we have a very diffuse, somewhat semiautonomous social service network, where the agencies are responsible to independent boards as opposed to the Chief Executive.

We have an unprecedented level of cooperation among these agencies now, but, nonetheless, we still have frustrations. Our payment levels, the State match payment levels, are somewhat low in large part due to the dearth of tax dollars. We are at the mercy of world commodity prices, given our reliance on agricultural prices and fossil fuels, our manufacturing base is subject to currency fluctuations.

I want you to note, however, that our average tax burden is comparable to regional figures and somewhat greater when you consider ability to pay. But I think the most important statement in these remarks is that one reason for our dearth of tax dollars is the legacy of neglect the State government has had toward a large segment of our population.

Until very recently, we did not invest enough in the education, training, and health services of the poor, rural, largely black element of our work force. We have substandard skills levels and immobility in the job market which limits us to move to more profitable enterprises.

Fortunately, in our opinion, these political, social, and economic thinkings are changing. We realize now human capital is the most important element in the move to prosperity and, hopefully, we have begun directing these resources accordingly.

I would like to offer a few examples of our emphases on interagency cooperation in State government. Also, make note of our recent emphases on productivity increases within the human service delivery and, then, finally, give you an example of a couple of pet projects which I think, pilot projects which I think you will be very interested in.

We have a negotiated investment strategy for our social service block grants whereby the major players in the distribution of these moneys get together before hand and come up with strategy and policies and procedures for implementation, and divide up the service delivery so that there is less overlap. We have been able to reduce the administrative overhead from over 15 percent to 1 percent, and have cut down some on the interagency turf battles.

We recently funded a housing rehabilitation project in Northeast Mississippi using a host of different sources of Federal moneys. Just recently, we have funded two economic initiative projects in 2 of the 10 most depressed counties in the State. We asked those 10 counties to submit to us a comprehensive development strategy using CDBG moneys, Community Development Block Grant moneys. We said; tell us what it is that we can do to help you to address not only the economic development problems, but the human development aspects. This was rather successful in these two counties. Information is enclosed as to the specificity of the projects.

We are proud of the fact that we did not rely upon HUD to tell us what to do, that we went to the local people and asked for a self-needs assessment. We had a school nurse project, and I think Dr. Cobb later will comment more on that. The school nurse project funded in East Central Mississippi and right here in the Delta.

In one instance, the teen pregnancy rate went from 59 to 12 percent in the first year of operation. We do not pretend that these numbers will be consistent throughout the program, but the success at reducing teen pregnancy, substance abuse, child abuse, and neglect are phenomenal.

One of the major projects we are looking at, something I have included, is a corporation for enterprise development proposal that we are participating in with six other States, one of whom is Mr. Penny's Minnesota. A welfare reform proposal which attempts to explore the possibilities of self-employment as an alternative, one alternative to the welfare dependencies.

By utilizing various sources of moneys to identify the gaps in the service economy in the State and providing incubator facilities and limited technical assistance to some of these fledgling businesses, we will test this potential. During the transition to the healthy aspects of the economy, these individuals will be helped with the

child care, transportation, health care expenses, so that these disincentives will be minimized. We are using social service block grants and JTPA moneys for this.

Minnesota just recently solicited a waiver for the Medicaid portion of this project, and they agreed to allow us to copy their methods.

My colleague, Rims Barber, is involved in a long-range human development plan and agenda for the State that will be devised by the leading policymakers in the human services delivery agencies and advocacy groups.

Gentlemen, I would like to respectfully request your assistance. We just wrote to HHS asking for some money to fund this project. If you could see fit to assist us in that, we would be most grateful.

We are attempting to consolidate certain program deliveries here on the State level in an effort to improve efficiency. We in human development are under self-imposed pressures for productivity increases. We have gone to unit cost pricing for our aging meals service, cutting the cost 28 cents a meal this past year, which allowed us to serve a 130,000 more meals—home-delivered meals. As I say, we have unit cost pricing in all of the aging programs and, hopefully, we can move that to that process in the community services block grant proposals.

If I may offer some suggestions as to what we feel would be most advantageous, if you could help us by consolidation of similar transfer payment programs, such as food stamps and AFDC, we would be burdened with less administrative overhead and would also be able to put more money back into the service delivery.

If you cannot combine similar programs, then we ask that you allow us more flexibility at the State level. We applaud the block grant concept, but let me say—Congressman Espy mentioned substandard housing in the State, and I would like to echo our concerns for a program and give you examples of what we are trying to do with some limited moneys.

Right now, the low-income housing energy assistance program allows for up to 15 percent of that money to be diverted to weatherization for low-income housing. We match that 15 percent, which has been cut in half over 3 years, by the way, due to Gramm-Rudman and the like, with a DOE grant and some Exxon transfer moneys, some stripper well moneys—through the petroleum violation escrow fund—and weatherized this past year about 4,500 homes around the State, owner-occupied, low-income homes, with caulking, weatherization, windows, insulation, and the like.

It is difficult for us to try to convey to local service deliverers and recipients the logic involved whereby only 15 percent of the funds are allowed for attempts at permanent improvements. On one hand, we have annual payments toward utility costs, between $100 and $150 per person, depending upon the eligibility standards, and on the other hand, we have a one time $1,200 average upgrade of owner-occupied, low-income housing, which saves, over a period of 2 years the cost of the project itself. It also kicks money into the economy in terms of skills enhancement, carpentry skills, and the like.

Somebody has to sell us the lumber, et cetera. We feel it is a very good program. It is long-range oriented. We are not pitting the

stockholder of the utility company against the poor person. In our opinion, if we were to pit them, I think you know where we would come down, but that appears to be what one of the major concerns we have.

Finally, with the petroleum violation escrow funds, we feel, we get the impression, that we are expected to replace the weatherization moneys and the grants with those moneys. But as you well know, there are other entities in State and local government that have needs and requests for this money, and the escrow funds are not nearly enough to replace the LIHEAP cuts.

Finally, if, in your grant modification procedures, you can devise a procedure whereby we will award success in terms of more efficiency in operation, creativity in the use of Federal moneys. We would respectfully request that these awards be implemented in some type of scoring scheme.

I would like to thank you and express our appreciation for the brief comments. If I could offer my assistance in whatever opportunity, whatever means available. Enclosed in your packet are some answers to questions previously submitted, and with that, I would like to turn it back over to you, Mr. Chairman.

[The prepared statement of Mr. Chism appears at the conclusion of the hearing, see p. 80.]

Chairman LELAND. Without objection, all of the material that you so care to submit will be entered into the record as an official part of your testimony.

Mr. Armstrong.

STATEMENT OF LOUIS ARMSTRONG, DIRECTOR, MISSISSIPPI LEGAL SERVICES COALITION

Mr. ARMSTRONG. Thank you, Mr. Chairman.

I appreciate the opportunity to present the views of the Legal Services Community in Mississippi regarding the problems of the poor.

The six legal services corporations in Mississippi provide legal representation to eligible poor population of——

Chairman LELAND. Mr. Armstrong, if you could suspend. Let me ask you to pull the microphone closer so that the audience can hear you adequately. Can you in the back hear everything that is being said? We will try to facilitate that.

Mr. ARMSTRONG. I should know how to use these microphones by now.

Again, Mr. Chairman, I appreciate the opportunity to present the views of the legal services community of Mississippi regarding the problems of the poor.

The six legal services corporations in Mississippi provide legal representation to an eligible population of 587,000 poor Mississippians. Many times, the legal services offices are the last resort for clients who otherwise have no recourse as a result of decisions made by bureaucrats which violate Federal and State mandates of legislative bodies.

In June of 1984, this committee visited Mississippi to assess the effectiveness and accessibility of Federal food stamps, food assistance programs in rural Mississippi areas. After more than 3 years,

the situation has gotten worse. Continuing Federal reductions and the lack of available State funds have reduced the situation in Mississippi where thousands of children go to bed hungry each night. A situation where hundreds of our elderly suffer needless pain and even death as a result of the lack of adequate medical care. Where thousands of Medicaid mothers have to make the decision between food and shelter or food and heat.

Specifically, the most serious problem related to food stamp participation in Mississippi is the sheer lack of adequate staff to provide services to thousands of eligible clients located throughout rural and urban Mississippi. Federal law mandates that within 30 days after initial application, a food stamp applicant should have food stamps in hand. That is not the case in Mississippi.

In Mississippi, it is certainly not the case. The most frequent complaint we hear in local legal services offices regarding food stamp participation is the time it takes for recipients to receive food stamps after the initial application. That time period reaches far beyond the 30-day limit required by Federal legislation.

Additionally, food stamp clients are not notified when changes are made in the eligibility. For instance, recently, a client was terminated from the Food Stamp Program due to an increase in income which was reported to the local office. The client was never notified that she had been terminated until she arrived at the welfare department to collect her food stamps. She had not prepared for such a hardship, so this family went hungry several nights during the month.

There is a serious problem with the flow of information between the clients and the welfare department. Again, this is a result of a severely understaffed public benefits system due to the lack of available funding, both Federal and State.

I would urge the Congress to require the States who participate in Food Stamp Programs to maintain a better staff to client ratio in order to provide adequate services to those clients. [Applause.]

The Aid to Families with Dependent Children or AFDC programs in Mississippi is one of the lowest in America. The maximum AFDC payment in Mississippi is a $144 per month. Many times, the cost of utilities exceeds their meager amount.

The struggle to maintain heat and shelter during the winter months in Mississippi is a constant crisis situation for AFDC families. Again, States who participate in this program should be required to provide a minimum level of assistance based on a more equitable formula than the one we are now using.

If an AFDC family loses their check or it is stolen or they simply do not receive it as a result of a bureaucratic error, the client must wait a maximum of 45 to 60 days in order to receive a new check.

This particular policy creates extreme hardships on families who must rely on AFDC for total income support. We urge some modification of that regulation so that while the verification process is underway, AFDC families are able to continue to receive some assistance.

Within these few minutes allocated by this committee, I have tried to address the broad range of problems related to food stamp participation and AFDC programs. The Mississippi Legal Services

Coalition and the entire legal services community is available to provide you with more detailed information regarding these issues.

We urge you to return to our Nation's Capital with firm convictions to address the policy initiatives we propose as well as those which you are certainly aware of in regard to the improvement of the delivery of food and nutrition to our Nation's poor.

Thank you.

[The prepared statement of Mr. Armstrong appears at the conclusion of the hearing, see p. 195.]

Chairman LELAND. Thank you, Mr. Armstrong.

The Chair now recognizes Mr. Rims Barber of the Children's Defense Fund.

STATEMENT OF RIMS BARBER, DIRECTOR, MISSISSIPPI CHILDREN'S DEFENSE FUND

Mr. BARBER. Thank you, Mr. Chairman.

Members of the Select Committee on Hunger, I am pleased to once again come before you. Although I am sorry that once again we find that hunger is with us, and that there is still a necessity for you to journey to ferret out these kinds of problems in our great land.

Despite the summer heat, I can assure you this is not the Sun Belt. That is maybe in Atlanta or somewhere else or Dallas or Houston, but it is not here in Itta Bena. This is the economic shade belt of the Nation.

It is here that a higher percentage of people are left behind, dependent on government assistance, than almost anywhere in the Nation. Hunger hangs over us in large part because we have not seen any of the economic recovery that occurred in other parts of the country.

From 1983 to 1986, the unemployment rate in the five-county area surrounding where we are right now actually went up, from 15.1 to 16 percent. I have supplied you with some materials on some basic information.

For the black population of this area, times are even worse. One out of every four blacks are unemployed. Blacks are 62 percent of the population of this area, 54 percent of the work force, but they are 84 percent of the unemployed.

Nearly half the black population must rely on food stamps to survive. Therefore, whatever you do about our national policies to meet the needs of the hungry is very important to the lives of the people in this area.

Life is seemingly better than it was when the outside world first discovered hunger in the Mississippi Delta a little over 20 years ago. Poverty is less grinding, although as we saw this morning, it is still there.

Because we have struggled with help from the Federal Government to open up opportunities for our people, there are some concrete improvements in life at this edge of the Nation. Mothers are three times less likely to die in child birth. Infants are less than half as likely to die in their first year of life and birth defects have been reduced by half. Children are half again more likely to stay in

school and proceed on to graduation, and twice as many kids are going to college as did back in those days.

Civil rights laws and Federal programs have made a difference, yet these are the only things that stand between many people and starvation or death. While we have made progress, there are still barriers, still much to be left done.

As has been noted by Congressman Espy, we are very proud of the improvements that have been made in the area of infant mortality. In 1983, the State infant mortality rate was 16.1 per thousand live births and 21.7 for black infants. Three years later, the 1986 figures show that we had a 12.3 rate for the total population and 16.2 for blacks.

Leflore County has made the most significant drop in black infant mortality, from, in 1983, 31.4 to 19.8 in 1986. That is in that short 3-year span since you were last here. Nevertheless, the black infant mortality rates for this region are higher than many Third World countries. We still have a ways to go.

We have made some improvements in securing access of needy people to Medicaid and other programs, yet barriers remain. We still get reports of 3- and 4-month delays in eligibility process for Medicaid or food stamps, and the struggle each year to secure the State funds to provide the services for our people.

There are no jobs. You can see closed plants all across this State. Thousands of people who used to rely on small town factory work to support their families can no longer see any hope that such jobs will return.

Recently, when driving through the Delta, I saw a scene that reminded me of the old days. Hoe hands spread across a large field chopping cotton. Just when we think such grinding work is behind us, again it appears that farmers who cannot make payments on machinery or chemicals are forced to recruit such labor and people are driven by hunger to accept such day labor jobs. Others seek out the only jobs that seem to be available, part-time work passing out hamburgers across a counter, never making enough to be able to take their children to the fast-food restaurant in which they work.

I am not sure what the answer to the jobs problem is, but trust that you Members of Congress will work on saving American jobs and bringing some economic life to this backwater of America. In the mean time, our people must survive. We must see that they have food and shelter. You can help by protecting the programs that provide Federal entitlement to food and income assistance and health care. You can work for housing programs that will improve the availability of decent housing and provide some jobs producing that housing.

You can also labor to see that Congress does nothing stupid, that programs are not dismantled leaving people unprotected. That so-called welfare reforms are not passed to force people to work at nonexistent jobs. Any national program must work not only in communities with good economic activity but in places like the Mississippi Delta.

Remember the things you have seen here today. The homes we saw this morning in Rome and the lives of the people in them have changed little in the last 20 years. As I ate a delicious lunch, I could not help but think of one of those women who said that she

had not had meat for over a week and the little boy that the chairman gave a quarter to who was off to buy a banana, and if we are thinking about welfare reform, what are you going to do for those families there in Rome, where are they going to work.

Remember them, remember the poverty, the lack of jobs, the lack of resources, so that you can ensure that Congress looks out for the needs of all Americans.

Thank you.

[The prepared statement of Mr. Barber appears at the conclusion of the hearing, see p. 198.]

Chairman LELAND. Thank you very much. [Applause.]

Let me say to you that welfare reform is not a catch-word for the dimunition or a destruction of those social programs that have been so helpful to our many people of this country.

Let me just also say in response that the leadership of the House at least has decided that it would develop a task force on welfare reform in order that we can reform our welfare system with compassion and sensitivity as opposed to dismantling it.

Mr. BARBER. That is all I am asking, sir.

Chairman LELAND. I understand. I just wanted, as a matter of illumination, to clarify the position of many of the Members of the House.

Mr. BARBER. I was not trying to cast aspersions on anyone, but there has been a lot of loose usage of the terminology and, therefore, felt that if we are looking at what works in Boston, MA, may not work in Rome, MS, and we have to have that kind of perspective, and I am glad that you were there this morning so that when you think of what you are doing with the laws, you think of the people that are going to have to live with what comes out of the other end.

Chairman LELAND. Well, let me assure you that each and every person on this committee here today is working on those problems of the complicated nature of what the welfare system is all about. Welfare reform also means, by the way, an attempt to try to develop a one-stop shopping mechanism for the purpose of streamlining welfare administration—the administration of programs to support the poor, so that they have easier access to services.

We are also looking at, by the way, streamlining the applications and the process through which eligibility to participate to become eligible or to be made eligible for in these programs is determined.

By the way, we welcome your admonitions about what we should not do, believe me, and I do not want you to respond defensively. I was just glad that you would raise the issue because there are those in the Congress and in the administration who, sometimes out of ignorance or sometimes out of insensitivity, will advocate the dissolution of those programs that have so greatly helped so many poor people here and around this Nation.

Let me turn now to Mr. Chism to ask a couple of questions.

Mr. Chism, based on current projections, how do you expect the revenue loss resulting from the elimination of the sales tax on food stamp purchases to affect funding for social service programs in this State?

Mr. CHISM. Mr. Chairman, to make a long story short, a lot of people in Mississippi thought that there was a causality. The num-

bers show that the State lost $16 million total revenue in the entire fiscal year.

Last year's budget was an increase overall of about 6 percent. The social service budget increased about 4.2 percent. We cannot seem to indicate that the legislators—we cannot seem to establish that the legislators used a vindictive approach against the social services.

I think if you look at the impact on 6 percent more money for the poor people to spend then, by and large, it was a good move. I do not think anybody will dispute that. It hurt us financially on the State level, but in terms of the poor person in the State, it is probably the best thing.

We have a very regressive tax structure in the State. Sales tax is 40 or 45 percent of our general revenue, general fund revenue, and anything to lighten the burden, to redistribute the burden is better.

So, the wailing and gnashing of teeth that I think you heard was probably a bit over-stated.

Chairman LELAND. Thank you.

Based on your experience, what have you found to be the major barriers to participation in the Aid for Families with Dependent Children, Food Stamp, and Medicaid Programs?

Mr. CHISM. Well, to be honest with you, I think that the statements that Louis made are perhaps more applicable in this case given my lack of interaction on a daily basis.

I think from a theoretical perspective and what we have found in looking at other States' welfare reform proposals, the barriers seem to be getting off the program more so in terms of this frustration with the lack of jobs as an alternative.

As you mentioned, in the rural environment, transportation to and from jobs. In Boston, MA, you have got public transport, but in Rome, what do we have? We must coordinate our public transportation to ensure that those individuals making the transition do not have to spend a large percentage of their income.

Child care was such a large, very important need here for the welfare mothers trying to make the transition. The thing we find they are most afraid of is losing the medical benefits, and there are charts that show that a $3.35 an hour wage is not enough of an incentive to make the effort to move oneself. [Applause.]

We realize that, and we, in conjunction with the State welfare department, are looking at alternatives and applaud what is going on in Congress now.

The policy proposal included in the document seemed to indicate that we must remove these disincentives before we can ever make the transition. We find that most people want to work, that most people have good attitudes about it, but it does not make sense to leave your kid at home unsupervised and take a chance on not getting sick and being able to feed him for a $3.35 an hour job.

We realize that, and we are trying to come up with the answers—we do not have the answers yet, but we realize that that is the major problem.

Chairman LELAND. I take it you are fairly well-versed on the proposals before Congress to deal with the so-called welfare reform?

Mr. CHISM. Well, we are afraid, just as Rims mentioned, that you are dumping it on us without some additional money; and for Mis-

sissippi in this case, I think, it will be incumbent upon us to assume a greater financial role.

I think there has got to be some money associated with it. The block grants and the waivers for participation, either through the Medicaid or JTPA funds, will give us a great deal of flexibility and I think everybody agrees the State has got to come up with some more money for it to work, and I found, at least among the politicians, at this point in time, a great deal of morale support for the idea on the State level.

I am not sure what they will think once they figure out how much it will cost.

I think my boss and his successor will be willing to work with that.

Chairman LELAND. Very good.

Mr. ARMSTRONG. Mr. Chairman, I would just like to point out——

Chairman LELAND. Please.

Mr. ARMSTRONG [continuing]. That the legislature is still dominated by a rural planter mentality and is very antipoor, and the problem is that trying to get anything through the legislature that smacks of assisting poor in any way is a suicide effort.

Chairman LELAND. You know, there are many people who are very much opposed to Congress proposing so many things that impose guidelines for States—the so-called States rights movement.

I hear you suggesting that sometimes Congress might need to intervene and to impose certain guidelines so that——

Mr. CHISM. Well, NGA has taken a leadership role in this, and Ms. Hogan and other individuals in the State programs have been very supportive, and we think that that is a positive feature, that it will not be as foreign an idea once it gets here.

Chairman LELAND. Very good.

Mr. Armstrong, you discussed in your testimony the delay in certification for food stamp benefits. What is the average waiting period for AFDC benefits?

Mr. ARMSTRONG. We do not have any real figure. We are doing on an analysis right now to try to get some handle on exactly how long it is taking. I have met with the chair of the welfare, State welfare board, and discussed the problem with him, and his staff is aware of the problem, and Dr. Griffin is certainly aware of the problem and is concerned about it.

But the situation is that there is no money to provide additional staff to serve these people. So, the department knows it is in violation and there is nothing that they are able to do about it at this point.

We are in a position where if we file suit and we will ultimately win, what is the remedy. The remedy would be asking—going to the legislature and asking the legislature for more money and the legislature will again do what it has always did and say no.

So, we are assessing that. The remedy has been that we have won these cases in several States. Legal Services has in the past 6 or 7 months, but the same remedy is one that cannot be enforced because you cannot force the State to appropriate funds it does not have.

Chairman LELAND. Mr. Barber, there seems to be a common concern across the country that benefit levels are, indeed, inadequate, yet many believe that the amount of money spent for social programs at the Federal, State, and local levels should be sufficient to close the poverty gap.

How can we improve public assistance programs so that they are much more effective or, should I say, that they more effectively reduce poverty?

Mr. BARBER. That is a really tough question. So, excuse me if I take a moment to try and collect my thoughts.

Clearly, we must have benefit levels that have—hold the promise of reducing poverty. Currently, our benefit levels for a family of three, which is your average family on welfare, a $120 a month does nothing to eliminate poverty. It is so far below the poverty level, you know, as to be 15 to 20 percent of the poverty level.

We are just barely giving people some survival money and that does not always make it. So, we have got—looking at it from our Mississippi perspective, clearly, the first goal is that people need more money.

Now, we have tried through a variety—the Federal Government has tried through a variety of programs to provide services for people of a great variety of types, ranging from head start to education, compensatory education, to health care, those kind of things.

If you stack all those up and took all that money and eliminated the services, which I am not advocating, and redistributed the money, you might—some have argued that that would have a greater effect on eliminating poverty than the current programs we have.

I, however, do not take that position. I think that we need to see that there are certain basic things that people must have if we are going to call ourselves a civilized nation, and find a variety of delivery systems to meet those needs.

In some areas, we will rely, continue to rely on the so-called free market economy. In others, we need to develop some more systemic reforms to better deliver services, so that everybody is assured that they can get health care or food or whatever it is that we, by consensus, agree are the basic necessities of life.

I am not sure that there is an easy—I know there is no easy answer to what you have asked, Mr. Chairman, and I am not even sure I can make a reasonable stab at it.

Chairman LELAND. That is all right. You have, and I appreciate that.

Mr. Chism.

Mr. CHISM. Yes, Mr. Chairman.

Block grants and waivers, which would encourage or allow flexibility on the State level, I think, as Mississippians in education and experience level increases overall, the opportunity or the ability to fashion specific solutions increases, and I think if you can give us some slack and trust us to make some innovative procedures, I think the political system is such now that—and we always have the guarantees that if we do step beyond those bounds, we can be brought back into line.

Consolidation of certain programs to reduce the administrative inefficiencies and perhaps regulations which would encourage State administrative officials to perhaps more money for funding if we were allowed to reduce our administrative overhead by X percent.

But I do not want to down play and I think it is important not to understate the State's obligation to make some common sense moves. I mentioned the executive branch reorganization in Mississippi. It is asinine for us to hire five different semi-autonomous social service delivery agencies that each deal with some aspect of a child's life, between zero and 18 years. It does not make sense to waste the money. We are moving toward that.

By the same token, we have programs within our own agency where employment training opportunities are provided by two different sub-agencies, two different divisions. For example, our community services block grant proposal for program and our job development training program may be funding separately unknowingly of each other in the same community of Greenwood GED training in different parts of town.

We are looking at methods to reduce that and, as I say, that is a State obligation. I hope we are moving in the right direction. We have got a long way to go because there is a lot of bureaucratic intransigents, but I think the initiative is here now and the scrutiny of advocacy groups is there.

Mr. ARMSTRONG. Mr. Chairman, since we are taking a stab at this question you asked here, I would like to just point out that I have been an advocate for welfare reform and public assistance programs and increasing the funding in that program, and in that light, I would just like to say Congress has to make the serious morale decisions to stop squandering our resources, sending funds to other countries and building bombs that we do not need, and start putting money into human development and human lives. [Applause.]

That is the first commitment, and we have Democrats who are voting up there for this just like Republicans are, and I do not understand that, but, you know, based on what our philosophy is supposed to be.

But not that I am a Democrat, mind you, but, of course, this is not a partisan discussion, I do not think, but what I really would like to point out is that as an advocate for the past 15 years, I am of the opinion that we do have to have welfare reform, but we have got to change the system and take it out of the realm of a political tool that politicians use to get re-elected.

More welfare is not the total answer. More funds, increase the amount of money that people are getting each month is not the total answer. The minds that need to be changed and we need to start thinking about how we are going to really create programs to get people off the system, to get people off the system, and that is through training, that is through beginning at the early stages of life where we provide adequate funding for education and for health care and for those kinds of other opportunities that will motivate people to not want to be dependent on anything but themselves. [Applause.]

So, I think you have got to—so, it has to really go to a commitment that we have to take a giant step forward and reform the

entire system and not just increasing the monthly amounts that we get, but to really direct, redirect the whole concept, and say that we are going to create programs that are going to get people off the Government payroll. They are going to get people into creating productive—and having productive communities and people want to do that.

But when you go out and a young person goes out and tries to get a loan to start a small business, self-employed, I heard somebody say here, if there is no loan money available, if there is no Vista capital available in the community, there will not be any self-employed people in that community. They are all going to be dependent on some other outside source of income.

So, looking at the whole concept of making communities self-sufficient through providing all those supporting services that they need is—which means more than just the food stamp, which I know you are here just specifically talking about, food and nutrition programs, but you have the ability to articulate at the national level our policy concerns here and they are broader than that and they indicate that we want to see a total revamping where we start concentrating on getting people off the system for real and not just giving them a job, picking up papers on the side of a highway somewhere for 6 or 8 weeks, and, then, when that is over, they go back, right back on the system. [Applause.]

Chairman LELAND. Mr. Armstrong, let me state to you that we are not—we do not try to limit our perspective to just feeding hungry people directly. We look at this problem as a holistic problem and we hope to find some solutions to this most incredible situation.

One other thing, and then I will yield to my colleagues, is that I hope that I did not hear you say that we should not give money to other countries for support and aid for development and so forth, particularly in the third world, that——

Mr. ARMSTRONG. I would be a lot more selective in the countries we are giving money to. I would certainly agree with that.

Chairman LELAND. Well, let me say that, and I hear you, and I understand exactly what you are saying, but our aid program, however limited it is, the millions of dollars that we put in some of the countries to help them develop in the area of agriculture——

Mr. ARMSTRONG. Specifically, I am talking about military aid.

Chairman LELAND. OK. Very good.

Mr. ARMSTRONG. Military, and we are talking about——

Chairman LELAND. Well, I am glad you clarified that. You are talking about the Contra issue and——

Mr. ARMSTRONG. Well, you got Contra. You got Contra. You got a lot of aid to some countries in North Africa that are not particularly democratic regimes that I would think you would not be supporting.

Chairman LELAND. Well, I can appreciate that because I think that we need to do more in some of the developing nations of the world to help people to feed themselves. By the way, we can do that without diminishing the efforts here in feeding our own people.

I will yield to my colleague from Pennsylvania, Mr. Kostmayer.

Mr. KOSTMAYER. Thank you, Mr. Chairman.

How many of the citizens in this State are on public assistance are children, Mr. Chism, percentage?

Mr. CHISM. I do not have those exact numbers, Mr. Chairman.

Mr. KOSTMAYER. And let me ask, to save time, Mr. Armstrong, while you are finding that——

Mr. BARBER. The number of children on AFDC, the latest count was a 125,423.

Mr. PENNY. How many are eligible?

Mr. BARBER. That is the number that has been certified and are as eligible from a computer print-out at the welfare department.

Mr. PENNY. That is approximately 45 percent. Well, that is fine.

Mr. BARBER. That is 75 percent of the welfare recipients are children.

Mr. PENNY. That is what I am asking.

Mr. KOSTMAYER. Seventy-five percent of the welfare recipients in the State are children?

Mr. BARBER. Right.

Mr. KOSTMAYER. Mr. Armstrong, do you agree with what was said about the block grant program, that it is a good program and ought to be continued? If I am misrepresenting your viewpoint, Mr. Chism, about the block grant program, you correct me.

Mr. CHISM. Let me qualify it. I think it is misleading to put programs in a block grant form and then reduce the overall sum.

Mr. KOSTMAYER. Just putting them in block grant form, even if you do not reduce it, do you think that is a good idea?

Mr. CHISM. The programs I spoke of specifically, yes, I would recommend that.

Mr. KOSTMAYER. Namely?

Mr. CHISM. Well, if we could take the JTPA, for example, rather than subdivide the titles 2 and 3, 2A, like that, I think the JTPA block grant would give us more flexibility.

Mr. KOSTMAYER. Would you then not leave it up to the legislature how to distribute those sums?

Mr. CHISM. Well, I think it comes up to the Governor's office the way it is done now. The chief executive of the State.

Mr. KOSTMAYER. Mr. Armstrong.

Mr. ARMSTRONG. Mr. Kostmayer, I believe—I serve on the State block grant advisory board, and had an opportunity to have input into developing the negotiated investment strategy, and I think that under the circumstances and with my experience, the block grant program was effective. We were able to rechannel and redirect some funds that were otherwise, we felt like we were not getting the best dollar—the best bang for the buck for.

Mr. KOSTMAYER. Go ahead.

Mr. CHISM. I will give you an example with SSBG block grants. An agency director under my supervision—head of Council on Aging—felt that the negotiations were not necessarily to the best of their liking, that if we had administered the money all ourselves and told each—told the welfare and mental health what they would have gotten without any regard for their input, we would have received more money through the Council on Aging.

But I believe in the final analysis, our Council on Aging, certainly all of human development, feels that the best interests of all the people were served.

Mr. KOSTMAYER. Let me ask you—or perhaps Mr. Barber to what extent family planning services are provided in Mississippi.

Mr. CHISM. Well, we had a real sticky problem with dealing with the issue of birth control in schools, with the religious implications and the problems with advocacy of abortion. That is a very hot political issue. I am sure it is everywhere.

In the schools, we just instituted or the legislature funded a state-wide school nursing program to a limited extent. Rims can give you more of the numbers. That came after a pilot project run through the SSBG, that these people agreed on.

Mr. KOSTMAYER. Is it family planning programs in the schools?

Mr. CHISM. No. It is very limited. There is a curriculum proposal by the State Department of Education which will have to have a legislative approval of, and we are probably several years down the road from a——

Mr. KOSTMAYER. What kind of family planning services are available to the poor women in Mississippi who want to plan their families?

Mr. CHISM. Very limited. The health department has certain counselors, but in terms of a legislatively funded separate program, it would be through the health department.

Mr. KOSTMAYER. Through the county health department?

Mr. CHISM. Well, the State, which decentralizes it through the county health department.

Mr. KOSTMAYER. And do the county health departments make those services available or to a very limited extent? Yes, sir. Go ahead.

Mr. BARBER. They are available in every county health department in the state. Whether there is sufficient outreach so that people know about them, whether there is sufficient education, whether people are working in ways to really join hands with these young people so that they understand what the necessity for it, that is still subject to question, you know.

Mr. KOSTMAYER. Well, is this a serious problem that needs to be addressed?

Mr. BARBER. We have an extremely high rate of teen-age pregnancy in this State, and we are attempting to address it in a variety of ways.

Mr. KOSTMAYER. To what measure of success is it being addressed in the State?

Mr. CHISM. We have a task force——

Mr. KOSTMAYER. You give yourselves an A, a B, a D, or a F?

Mr. CHISM. A for effort, probably a C minus for effect thus far.

Mr. KOSTMAYER. A for effort, C minus for effect.

Mr. CHISM. But we are getting better. We have a goal. Our Commission on Children and Youth has a goal of reduction of teenage pregnancy, I think, by 5 percent as of 1988, January.

Mr. KOSTMAYER. Have you been able to measure in the past several years whether it is on the decline?

Mr. CHISM. That goal was set in January of 1984, and it is definitely declining. There is a task force report in your documentation which outlines the success thus far.

Mr. KOSTMAYER. Would you like to see more done in this regard?

Mr. CHISM. Well, obviously. If so, we reduce the burden on the taxpayer, we reduce the burden on the mother, she has fewer disincentives to work. If you improved her family environment by not bringing on children that were not planned for, the psychological situation is better, and we all benefit overall.

Mr. FLAKE. If the gentleman will yield.

Mr. KOSTMAYER. Yes, indeed.

Mr. FLAKE. Just one question. You talk about the goal. Can you mention some specifics in terms of how you intend to reach that goal? What specifically do you do to reduce those numbers?

Mr. CHISM. There are selective teen parenting, both public and private sector funded, peer-oriented programs. For example, in the Jackson Public Schools, there is a recently instituted program funded by one of the private sector institutions that utilizes teen mothers for advocacy of restraint or proper planning in talking to their peers.

The Commission on Children and Youth has a legislative advocacy role in terms of trying to inform us statistically where we are. We try to support the efforts of the health department in dissemination of this information, given our size and our role, I mean, our mission, that is rather limited, but those are some examples.

Mr. FLAKE. Is it a question, as a part of that advocacy, toward a position of supporting abortions and asking——

Mr. CHISM. No, sir. We do not. To my knowledge, no one in the State government has taken that position publicly. I think the Federal guidelines, by which we received this discretionary grant, prevent us from advocacy in that position.

I know as a policy position, the Governor's office does not advocate that.

Mr. KOSTMAYER. One more question and I will stop.

As to what extent, to be blunt, is the State participating in the distribution of family planning devices to young men and to young women in this State?

Mr. CHISM. The health department has, you know, boxes and boxes of condoms available and pamphlets of information, and——

Mr. KOSTMAYER. I do not know whether folks need boxes and boxes of them, just a couple.

Mr. CHISM. I was referring to the storage supplies.

Mr. KOSTMAYER. And are they being distributed throughout the State?

Mr. CHISM. Yes, sir. They are in the local health departments. As Rims mentioned, the effectiveness of this approach——

Mr. KOSTMAYER. But in the rural areas, are they being distributed in an active outreach?

Mr. CHISM. I cannot answer that.

Mr. KOSTMAYER. Pardon?

Mr. BARBER. It is less effective in the rural areas of this State than it is in our towns. It just is, and outreach is one of the problems, transportation, the smallness of the place meaning that people do not want to go to the health department because somebody will see them go in there.

Mr. KOSTMAYER. Well, I understand. I appreciate your answers. I am sorry to have taken so much time. This is, incidentally, no less a problem in my State than it is in yours. It is a serious problem in

Philadelphia and in Pennsylvania, not only in Mississippi. It is a problem for all the country, not just your own State.

Thank you very much. Thank you, Mr. Chairman.

Chairman LELAND. The Chair would like to acknowledge the presence of the State Attorney General, Mr. Ed Pittman. I want to thank you very much for being here, Mr. Attorney General.

Mr. PITTMAN. Thank you, Mr. Chairman.

Chairman LELAND. Mr. Mfume.

Mr. MFUME. Thank you very much, Mr. Chairman.

Mr. Chism, this morning, I had an opportunity to visit a family down in Marks and, unfortunately, was not able to meet with the man of the house, who was out working the fields. He sharecrops there. I met with his wife, and I met with many of his children. I think he has about 11 children.

She, in addition to her own children, has taken in two smaller children from another family because they were on their way to a foster home because of the requirements concerning many of the—well, the regulations and the fact that the mother was not working and the state assumed that it would be a better thing to send the children off to a foster home.

Well, suffice it to say, she took them in and she has all of them there. Her husband works seasonally, as you would imagine. In the winter, the income comes from his unemployment, which ironically enough exceeds the amount of money he makes when he is working. There are no medical benefits whatsoever, and I listened intently to Mr. Armstrong's testimony.

He suggested to this committee that one of the actions we might take when we return to Washington is to find a way to require States to provide a better staff-client relationship with those persons that they serve who are, in many instances, receiving food stamps or AFDC.

Now, the interesting thing about this particular family and the reason I raise this is that they are receiving food stamps but were notified by the county just a month or so ago that their food stamp distribution center was being relocated. It is now 38 miles from where they live. If they are not there on time to get the food stamps, they have to provide written notification as to why they were not there.

There was no notification that the center was moving until they got there. There is no communication to the family at all about new government guidelines or other options that are available, and I would like to know that in the interim, between the time that this committee or others are able to impress upon other Members of the Congress and, in fact, agencies that there ought to be some requirements for States, can you assure this committee that the Governor of this State will take a stronger role in assuming that responsibility without it having being mandated for the Federal Government, so that this sort of thing does not occur?

It is a bad situation.

Mr. CHISM. No, sir. I cannot under the current executive branch structure of this State. If that individual were to call the Governor and express the plight of his circumstances, the Governor of this State has no statutory authority to do anything about it.

Mr. MFUME. So, the Governor has no control over the distribution centers; they just move when they want to move?

Mr. CHISM. No, sir. The Welfare Commissioner of the State of Mississippi—who is appointed by an independent board of welfare commissioners, board members, is responsible.

The Governor does have power of advocacy and, in this situation, we have a welfare commissioner who has had an unprecedented level of cooperation.

Mr. MFUME. With this Governor?

Mr. CHISM. Yes. With this Governor, and I am assuming the next one. He is a new commissioner and has an exciting approach. But as far as the day-to-day operations, the Governor of this State does not have the authority with which to make those policy decisions.

It is similar to having independent cabinet officials in Washington. The Director of HHS not being answerable to the President of the United States.

Mr. MFUME. Well, I would not want to go that far. The President has a role of advocacy, just like the Governor does, and let me rephrase my question.

Would the Governor take an active role in advocating that until there is a Federal requirement that he would use his influence on the welfare commissioner to see to it that there is an exchange of information, that people are notified?

Mr. CHISM. Yes, sir. I have taken note of both Louis' comments and yours, Mr. Congressman, and correct me if I am wrong in interpreting your suggestion that in the event these relocations occur, changes in Federal regulations or State regulations occur, we find a better way to communicate that to the clients.

Mr. MFUME. Well, no, that is not correct. Not in the event, but in absence of the event. If there is a demonstrated effort to just assume a greater role in communicating to the people that the commissioner serves.

Mr. CHISM. Yes, sir. I will give you my commitment to stress that to both this Governor, who retires as of January, and the incoming administration that this is a need.

Mr. MFUME. Welfare Commissioner is elected state-wide?

Mr. CHISM. No, sir. He is appointed and serves at the will and pleasure of the State welfare board.

Mr. MFUME. Who appoints the board?

Mr. CHISM. Governors over a staggered—over a period of 12 years. So, no one Governor at this point in time has a majority control over the board.

Mr. MFUME. How many members are on the board?

Mr. CHISM. Between six and eight.

Mr. MFUME. Rotating terms?

Mr. CHISM. Yes, sir. Staggered terms.

Mr. MFUME. Will this new Governor have some appointments on the future board?

Mr. CHISM. He may have all of them if he stays.

Mr. MFUME. Well, that would be nice. It would, because I am afraid you are going to tell him how I feel. Well, tell him I hope the good Lord is looking out for him and that he gets a chance to appoint all and that there really is an effort to communicate better.

I mean, if you do not have information, you cannot make good decisions, and if those decisions hinge on whether you eat or you have a place to sleep, how your family gets along, it means all the difference in the world to some people. It really does.

I would appreciate it if you would communicate that to him.

Mr. CHISM. Yes, sir. I shall and the current commissioner of welfare is here today, and I am sure he is taking note of these——

Mr. MFUME. Good, good. Where is the current——

Chairman LELAND. Let me introduce the current Welfare Commissioner, Thomas Brittain. Would you like to come forward and present yourself?

STATEMENT OF TOM BRITTAIN, COMMISSIONER, MISSISSIPPI STATE DEPARTMENT OF PUBLIC WELFARE

Mr. BRITTAIN. Thank you.

Mr. MFUME. We met a moment ago. I did not know you were the man that I wanted to talk to.

Mr. BRITTAIN. Let me set a few things straight, if I may.

Mr. MFUME. Sure. Go right ahead, Mr. Commissioner.

Mr. BRITTAIN. A couple of things. No. 1, there has not been a movement of the food stamp distribution points that has been authorized by myself and where those have taken place by anybody in the field, they have been corrected. That is the first point.

The second point is that it is rather easy to talk about whether there ought to be better communications between the field staff and/or the headquarters staff and the clients, when, in fact, as I just returned from a meeting with 30 commissioners from other States around the Nation, they have case loads of a 123-126 per worker. Ours are 325 to 350 per worker.

In addition, at the beginning of last year, we had a $6 million cut in a $39 million budget. About a week after I joined the organization here, we learned we had a $4.1 million cash shortfall. In spite of all those factors, I want to return from that rather emotional statement, because our people in this State have carried loads throughout the year that are enormous. They have served the clients as best they could with an untenable situation, and I do not apologize one with for what any of them have done, unless they have done something in error, as against a particular client.

Second item is they have done that—carried the highest caseload in the Nation—and have actually reduced the error rate that the Federal Government puts upon us if we make mistakes, and by that count, we have received four letters of commendation from the food stamp FNS organization in Washington, from the AFDC group, from the Agriculture Committee, Mr. Bowen, and from others.

So, the group has done, I think, a phenomenal job. Now, off of that and on to some pro-active things, if I may.

You all have asked some questions here today that these gentlemen—the invited panel from Mississippi—have not been totally prepared to answer, and I would like to try to answer at least one of them.

You have asked us how we would deal with a minimum benefits situation——

Mr. MFUME. Mr. Commissioner, before you would, let me just reclaim my time and finish my point, and I will yield.

Mr. BRITTAIN. Thank you, sir.

Mr. MFUME. With regard to the movement of the center, I assure you that that has not been corrected. Congressman Kostmayer and myself have both talked to this family and that is, in fact, the case relating to the family there in Marks, and maybe if you could have a staff person follow up on that, you might find it to be true.

Second, that I realize that you are working with resources you have to try to do a good job as you see it. Sometimes we can be a little more creative, I think, and when I talk about communicating information to people, it does not necessarily mean doing it through a case worker. I mean, everybody has a radio and radio stations are mandated with public service announcement time that they have to give.

I mean, there are other things that can be done working with the Postal Service to distribute things through the mail. The utility companies, to a large extent, will distribute information, but if those approaches are never taken or not explored to their fullest, then we might be missing opportunities that we have to communicate to people who do not have the normal sorts of communications that some of us might enjoy.

Mr. BRITTAIN. We fully understand that, on the one hand. On the other hand, again, I am not sure that in the brief context of our discussion today that you can fully appreciate and understand our situation. I do not really expect you to.

What I would like to further add, however, in the way of creating a new solution is you all have asked today about the welfare reform movement, about what we can do to keep from getting mothers, young teen-age girls, into motherhood earlier than they should, what we can do to get people into jobs and so forth.

We have a rather extensive and creative set of programs already going in those areas. We believe strongly that you cannot, even with contraceptive measures, deal effectively with teen-age pregnancies unless you begin very, very early in life, even pre-school, and we have so initiated a program in one of our counties here with a very large school system to begin to work that into the school curriculum in terms of matters of health, matters of responsibility, matters of learning about economics. What does it take to live in today's world, how do you make money, how do you spend money, and how do you retain money?

Those programs are going on in spite of our staff shortages. In addition to that, we have looked in terms of what Mr. Chism indicated, consolidating some of the State and Federal efforts to get more productivity out of the systems that are there.

We have already in place some of the things that you are familiar with in terms of the House bill 1720 that is in Congress now as well as in the Moynihan bill, and we would like to ask consideration of what is at least a part of what is asked for in the Reagan bill.

We do have a work program going on a very short distance from here in your home territory in Clarksdale. We have a program going there that involves education, that involves work programs,

not just for cities and counties, but getting people employed in private employment.

Ten out of the first 39 clients that were in that program now have jobs. We emphasize child support payments and child support, via established paternity, two of the factors that the congressional legislation that is now in progress and I am emphasizing, we did that last legislative session.

The same applies to child care. We put as much emphasis on those kinds of factors as we need. Now, I feel that though Mississippi is not in the same economic base that some other States are, that we can make progress, we can work our way through this situation. It will simply take a longer period of time.

We in no way again apologize for the efforts of our staff, except where they have made an error. If, in the case that you have mentioned, sir, if, in fact, a staff member has made an error, has moved a food stamp distribution point and should not have done so, then, in fact, that person will be helped to move that food point, that food stamp distribution point back to where it was before.

We have already had that occur in a couple of cases where there was miscommunication from the headquarters office to the field by one of our staff members. Those two situations were corrected, and, so, I do appreciate your comments and do appreciate your inputs, but, again, I would like to emphasize that we are going to continue to work on some pro-active innovative programs that we hope will deal with people, (1) keeping them off of welfare, (2) once they are on, to serve them more effectively, and (3) to help them get off once they are on.

And in that sense, I do appreciate your time, especially with our being able to come to you without being on your planned agenda.

Thank you very much.

Chairman LELAND. Mr. Brittain, I am glad you could be here to help respond to the committee's questions.

Mr. BRITTAIN. I just learned about this a couple of days ago, sir, and, so——

Chairman LELAND. Well, it is not your fault.

Mr. BRITTAIN. Well, it is quite indicative, you know. I think something that you all were talking about a moment ago and that is the need with any State to make sure that its organizational structure is, in fact, going to support what it is trying to achieve out there with major points.

Chairman LELAND. Great. Thank you very much.

The gentleman from Minnesota, Mr. Penny.

Mr. PENNY. Thank you, Mr. Chairman.

If I might ask Mr. Chism, you indicated that the overall State budget increased by about 6 percent last year?

Mr. CHISM. Six percent. Yes, sir.

Mr. PENNY. Is that social service funding that went up by 4.2 percent?

Mr. CHISM. Yes, sir.

Mr. PENNY. What kind of a budget did the Governor submit to the legislature and how does it compare with what you got in those two categories, overall increase, what did the Governor request, and what was his request for an increase in social service funding?

Mr. CHISM. I do not have those exact numbers, Mr. Penny. If I recall, the major differences in our—let us see. I cannot give you those numbers.

Mr. PENNY. Do you know offhand whether the Governor requested more for social service funding than the legislature appropriated?

Mr. CHISM. Because social service funding—because we have 212 appropriations bills, it is difficult for me on an impromptu basis to add up the totals. I do recall that the Governor requested more money in certain education budgets which are not included in this figure and less money in others.

I—without specific references to the social service program, I am at a loss for words.

Mr. PENNY. I just curious to know because——

Mr. CHISM. I do not think—no, sir. You know, in general terms, I do not think there was as much differential as to blame the lack of increase on the legislature's intransigence. I do not think there was that much difference of opinion, and I would hate to mislead you to thinking so.

Mr. PENNY. That is the point I was trying to get at, is to identify a request made by the Governor because, in most States, the chief executive does submit a budget——

Mr. CHISM. Yes.

Mr. PENNY [continuing]. Which then the legislature proceeds to——

Mr. CHISM. That is the case in most States, but in this State, we have had this practice only for the last 3 years. The Governor has been able to submit a comprehensive budget.

I do recall that one of the reasons social service funding was not increased as much, and by no means can I quantify the amounts, State dollars are allocated to match Federal dollars in certain social service categories. That is the bulk of the funding for my agency, Federal-State programs, goes just to match or to provide a match.

We had our budget cut by, I think the LIHEAP Federal amount went from $17.5 to $9 million. The weatherization grant was cut by 30 something percent. With the exception of the job development training budget, none of the Federal block grant, social service Federal block grants were increased.

The remainder of the Federal grant, block grant funds that came to our State that required matching funds from our office were smaller, but I cannot quantify the amount. What I am suggesting is that that is one reason.

Mr. PENNY. I want to find out, if you know, what proportion or what percentage of young people who grow up in a county like Leflore County end up staying there and how many move out after high school and move away from that community and to find work elsewhere.

Mr. CHISM. Once again, I do not have specifics. I do know that there is only one county in the Delta that has had a net population increase in 50 years, and that is Washington County, primarily because of the city of Greenville.

I grew up in Tunica County and if I am any indication, a large percentage of them catch the first bus out.

Chairman LELAND. Will the gentleman yield?

Mr. PENNY. Yeah, yeah.

Chairman LELAND. Did I understand you to say that you are an example of——

Mr. CHISM. I grew up in Tunica County.

Chairman LELAND. Tunica County.

Mr. CHISM. Yes, sir.

Chairman LELAND. And you caught the first bus out?

Mr. CHISM. Yes. I caught the first bus to Jackson.

Chairman LELAND. Thank you.

Mr. CHISM. I think it is indicative of, if I judge the Congressman's questions, one has to balance his or her own family obligations with expectations for financial and other personal rewards, and we found the case, in my case, which was indicative of many, that the economic opportunities are very depressed.

Mr. PENNY. Which brings us to the biggie. Is there anything you can do in rural Mississippi to create work there?

Mr. CHISM. In Rome——

Mr. PENNY. I talked to six guys standing out on a street corner. They were not working today because it rained last night, and even if they were working today, just field work, it is minimum wage, seasonal, and they are going to be unemployed much of the year.

Mr. CHISM. Yes, sir.

Mr. PENNY. What do you do with a Rome, MS, to create work? Are we in a situation where we are just going to focus only on the young people, try to get them educated and out of here, and then Rome is just a crossroads with nobody living there in the next generation?

What I am thinking about is a State, about that county and communities like that in the county, is this going to be——

Mr. CHISM. No. Mississippi was the first State in the Union 2 years ago to establish what amounts to a pool or a bonding authority for local governments to attract industry, and I am not talking about fly-by-night sweat shop industries.

We have instituted tax incentives for mid-level and higher tech institutions. We try to use our community development block grant funds, even though we get discouraged from doing so, to fund industrial infrastructure and public facilities, improvements in rural communities, so we make it more attractive for firms to relocate.

You know, if you are referring to Rome outside of Clarksdale?

Mr. PENNY. Yes.

Mr. CHISM. I think what we will see as we move to a consolidation of local government is that there is a critical mass of a community at which point the economic vibrancy is dependant, and if we cannot—I think we first have to concentrate on Clarksdale, and then make sure that we have an adequate infrastructure of transportation for the residents of Rome, but unless we go and we are encouraging this, unless we go to labor-intensive truck farming, there are very few other ways to utilize the natural resources in the Mississippi Delta.

Catfish farming is even less labor—no, not much more labor-intensive than the row crop farming. The alternative is a truck patch, gardening, and the like.

Mr. PENNY. I understand that that is a problem. You cannot have economic development in every curve up and down the road, but you have to focus on those communities where you think there is enough of a population base, enough other elements that come together to keep that community viable, and then hopefully surrounding communities——

Mr. CHISM. There are regional enterprise zones and key communities designated with certain tax incentives.

Mr. PENNY. One other concern I would have, though, is if part of the answer is that as young people come along, we give them the opportunity to have at least the basic training and the basic education so they have a chance to move somewhere else then and access economic opportunities, that we not simply move them from welfare dependency in Rome to welfare dependency in Jackson. And I do not know how you all are facing up to that issue, but if we are going to move people out of these rural poverty situations, I do not want to move them into an urban poverty situation.

Mr. BRITTAIN. May I respond to that? I totally agree with you. We have another small town here in the State of Mississippi wherein the mayor of a very small crossroads town, Tchula, has called us and asked if he could participate in the kind of program we started in Clarksdale, over in Columbus, Jackson, Meridian, and so forth. In that small town, his idea was that he was a seamstress many years in his work background. He would like to teach a few of our clients how to sew and begin sewing clothing that he can then sell to other people in that town, many of whom are also clients. They have got to buy their clothing somewhere; why travel, you know, 30 miles or whatever to get their clothing.

So, he is going to work with us and we are going to try to develop right there in that small community a small, you know, .5 or 10 person kind of company, if you will, and then expand it on from there. That is part of what I meant earlier when I said that I thought Mississippi is, in a way, rather unique.

We have got to climb our way out of this thing county by county, city by city, and step by step. So, when you have got people like that mayor of Tchula, a black mayor, who says,

> Hey, I understand the particular racial and other problems that these folks are facing, I want to work with you. We want to develop something here that we can develop into our own business and help these people to grow their way into some prosperity.

Mr. ARMSTRONG. Congressman, I would just like to add one thing to that, is that if we could stop or help bring industry to Mississippi by making it more difficult for companies to locate in Mexico and other parts of Central America, where they get cheap labor, if we could make it a lot more difficult for them to do that through some tax disincentives, then I think it will really help rural areas all over this country.

Mr. MFUME. We are going to get you on the Foreign Affairs Committee.

Chairman LELAND. The gentleman from New York, Mr. Flake.

Mr. FLAKE. Thank you very much.

Mr. Armstrong, I guess we will start with you, the point you just made is certainly a good one, but the reality is if you saw the recent documentary, what happens when towns develop in south-

ern rural areas, is that the people in the communities do not benefit by those jobs to the degree that we would anticipate mostly because they do not have the skills needed for industries that are coming in.

Therefore, what happens is that there is a migration of people from other parts of the Nation who are jobless but have somehow have been able to develop those skills to follow those jobs.

The question that I have is, How do we assure that in the process, the people like those who have been seen this day in Rome actually are ready and have the skills and training that is necessary so that when economic development does take place in communities like that that they can, in fact, be the people who get the jobs as opposed to outsiders being brought into their communities?

Mr. ARMSTRONG. I think that ensuring that the Perkins amendment is followed and that we have adequate vocational training in all phases for our citizens will really help us to move forward and develop that kind of skill level, so we will be attractive for those industries.

Mr. FLAKE. I think you understand that even with the Perkins amendment, that has not been the case in most of the Sun Belt development recently.

Mr. ARMSTRONG. Yes.

Mr. CHISM. One of the problems, Mr. Congressman, with the JTPA language is the definition and time tables associated with the performance standards. It is difficult for us to fund programs using JTPA the job skills and training necessary for more than a minimum wage job because we are forced to, on a 1 year to 18 month time table, show placement or demonstrate why we have not placed them, and in today's market, it takes more than 18 months to provide in most instances the skills necessary for a mid-level or high-tech level job.

And that is one way, greater flexibility on the State level in interpretation would help us.

Mr. FLAKE. All right. Before you——

Chairman LELAND. Will the gentleman yield for a moment?

Mr. FLAKE. Yes, Mr. Chairman.

Chairman LELAND. Let me suggest to you that the Education and Labor Committee is reviewing legislation to provide the kind of latitude that you are talking about, so that you will be able to enhance the opportunities for skills training as opposed to the limited guidelines that you have right now.

Mr. CHISM. Yes. We can train bricklayers all day long in Mississippi because we can do that in 18 months or 6 months, but if there are no houses being built and we need to train them to become something else, then we need greater flexibility.

Mr. FLAKE. I would like to just throw one thought out in response to what I keep hearing, I believe from everyone, and that is the issue of minimum wage. As you keep talking about welfare reform, minimum wage keeps creeping in, and my feeling is that it is suddenly suggested that welfare reform will be much more effective if there is a corresponding correlated attempt to try to raise the minimum wage level.

Is that what I am hearing? Anyone?

Mr. BRITTAIN. Can I tackle that? We had a great deal of discussion about that among the 30 commissioners in the recent past and that was a key issue. Every time you raise the minimum wage, however, there is a corresponding tendency to want to raise the benefits level of welfare clients so that they never can get the feeling that, Gee, if I work hard and get off of welfare, I will be better off."

We also talked in some great depth about the need on a congressional level, and the need in local legislatures in the States, to look closely at the employment security office, job training partnership act, personnel, and the relationship of those organizations to the welfare department.

When we send a welfare client in this state down to the employment security office, we do not have much hope that that is going to get that person a job. That is why, in fact, in the programs like in part II, we have got company presidents that have been coming and sitting around a table with us each month and we have a map of the city on the wall listing where the jobs are, listing where the people are, and those company presidents help us make some of those job placements because if we go through the traditional system that is now set up, they will not get jobs the way they should get them.

So, we think that raising the minimum wage would help, but unless somebody comes along right behind and says, "OK, let us raise the welfare benefit right along with that." As you know, in H.R. 1720, that was a key component of that bill before it was dropped, that was the desire to raise it to 50 cents over the median income.

Mr. PENNY. If I can tag on to that line of questioning, we in the Education and Labor Committee added a provision to the Welfare Reform bill that stipulated that your basic welfare benefits, aside from medical assistance, would be guaranteed if you took a job at minimum wage or maybe somewhat better than minimum wage.

What I mean by that is if you took the job, we would continue some kind of a welfare benefit to make up the difference as a way of encouraging folks to get into that job. But the evidence is after a few months, you move off minimum wage and it is just that first year or so where you really come out less well off for yourself and your family if you take a job because of the welfare benefits sometimes are better for you than that job.

This is in addition to keeping medical assistance benefits in place for those low-income wage earners. It is a supplemental payment and we felt if we did that in the Education and Labor Committee, we felt that it would be an encouragement to take the job and we thought it would be cheaper than if people, for the sake of their family, opted to stay on welfare instead of taking that job.

Mr. BRITTAIN. Yes, sir. I think that was a very smart move, and I think it will help immensely. Without that, we do not have a prayer of helping people get off the welfare rolls.

Mr. FLAKE. Thank you very much. Thank you, Mr. Chairman.

Chairman LELAND. The gentleman from Mississippi, Mr. Espy.

Mr. ESPY. Thank you, Mr. Chairman.

I know that the time is short, and we have other panels to get to, and I just have a toss-up question. Let me first say that I appreci-

ate each of the testimony heard today. It has been very instructive to me, and I think that it convinces us all of what I have known all along, that each of the presenters here today have a demonstrated knowledge of the subject matter and a very great grasp of it.

I stepped out a minute ago, but I wanted to follow up on Representative Mfume's line of questioning, and if this has already been answered while I was absent, excuse me, Mr. Chairman, I am sorry for that, but I reviewed the testimony of a transcript from the last visit of this committee to Mississippi in 1984, and I was particularly shocked when I learned that there was a difference between people eligible for food stamps, let us say, and those actually receiving food stamps.

I think the percentages in 1984, in fact, was that 32.9 percent of Mississippi's population was income-eligible to receive food stamp benefits, but at that time, only 19.1 percent of those eligible actually receiving the benefits themselves.

My question is, and I suppose anyone that would want to jump in and answer it is welcome, is that—what is the problem? I mean, we have heard about staff cutbacks. That certainly has an effect and an impact on delivery of services. We have heard about a problem of not being creative enough.

Congressman Mfume talked about the radio disseminating information. What is the problem? Has it changed? Has it improved? Is the gap still there for those who could get and those who do get? What is the problem?

Mr. BRITTAIN. Can I answer that?

Mr. ESPY. Sure.

Mr. BRITTAIN. We have had for the last 4 or 5 months a steadily increasing number of people joining the food stamp rolls. That, in combination with the fact that the staff was cut dramatically, has had the effects that we have all talked about here today.

But apparently more people are getting information about food stamp availability. I do not think ours is a matter of information. I think there is a goodly number of people who we call the working poor who make barely enough to get by and have some degree of food and shelter, who, for whatever reason, do not feel that they want to enter onto the food stamp rolls.

One of these days, I made this statement publicly about 6 months ago, I would like to move the welfare department here in this State to the point that anyone who is on welfare, who has a need for welfare assistance, need not feel ashamed, that they have simply reached a certain state in their life where the shipyards are laying off or the agriculture is down or whatever, that they need not be ashamed to be on welfare and that, therefore, will help that percentage gap.

Mr. ESPY. Great. Louis, I see you shaking your head. Can you take a stab at it?

Mr. ARMSTRONG. I would just like to add that one of the concerns is that again a lot of the elderly population that is just barely income-eligible do not feel like it is worth the hassle, the problem of going and applying for the food stamps and wading through the entire application process. They feel sort of intimidated by it, so they do not go through with it.

Of course, there is a small percentage of people who just do not know that food stamps are available and do not know how to apply for them or want to go in and make that application. They are intimidated by any kind of bureaucratic process.

Chairman LELAND. Will the gentleman yield?

Mr. ESPY. Yes.

Chairman LELAND. I heard this morning from a lady, a senior citizen, who I believe told me she is 77 years old. She gets both a pension from her husband's railroad pension of about $284 a month, and social security in the amount of about $212 a month, something of that sort. That is her total income.

She gets $10 a month food stamps. Now, that is, you know, that seems to be a ridiculous amount to me. Now, I will ask you both, Mr. Brittain and Mr. Armstrong to respond in just a second, but I might as well talk case work for Mike's interest, too.

She also owns her own home because of the work that her husband did. She lives in Rome. She is fortunate in that her husband had that job which was a credible, viable job that produced some income. She could own her little plot of land and have her house. Her house needs weatherization because now when it rains, water comes through the roof in the bathroom and also part of the kitchen.

She was recently successful in getting her food stamps mailed to her, but before she had to travel some distance to get her food stamps before and found that the amount of gasoline that she was using lessened the impact of the $10 a month that she was receiving in food stamp benefits.

Can you just tell me what—I did not mean to impinge on Mike's time, but——

Mr. ESPY. You are the chairman. You can do almost anything you want to.

Mr. BRITTAIN. Let me respond to that. You have asked two or three questions all at once and we are addressing them in two or three ways.

One is why the $10. The $10 is set against guidelines that are imposed by the Federal Government that we have no control over. If an individual client feels like the $10 is too little for whatever reason, they can appeal that through our office and often do, and when they do, it is reviewed not only by ourselves but it is reviewed by our board, and the board then determines whether it is working property or not, and I might add for the last 8 or 10 months, the board has been quite pleased with what we call administrative process.

The second issue is very important, too, and that is how does somebody who gets a minimal benefit, be it a check, be it stamps, be it whatever, how do they pay for the gasoline and all that, too. We have—we will be looking next week at a system that has been tried in Pennsylvania and a couple of other States, at two major areas.

One, we have already looked at, which is centralizing the issuance, where you mail out the food stamps through the mail. That is one approach. The second and slightly more expensive approach is one that has been tried in a couple of States and is called electronic transfer. It is simply that you get a little VISA-type card in es-

sence and you take that card and you take it with you to the grocery store. The card identifies who you are, does an immediate calculation of how much in the way of benefits you have got coming to you, calculates all that, feeds it back to our master computer back in headquarters, and goes on from there.

We will look at that again for the third time next Thursday and Friday. That is already scheduled.

Finally, in terms of processing clients more rapidly, we have one of the most progressive and innovative computer systems already in the 18 counties in the State of Mississippi—as is fed back to us by the Federal Government and by other State initiatives—and that is to get people into the intake interview, to take their application rapidly, process that information and determine whether they are eligible and get them on stamps.

That system will be in the rest of the counties, hopefully, in about another 8 to 10 months. It has been delayed by the fact that a much larger-size computer is needed.

Chairman LELAND. But is it true, too, that some people cannot get their food stamps mailed to them because they are considered to be in high-risk areas where, if they are mailed, there is the possibility the food stamps will get stolen?

Mr. BRITTAIN. We have had that consideration where it is at all feasible to mail it. So, in any high-risk areas, we will sometimes mail the stamps and see how it goes for the first several months and then if things are working out fine, we will do it. If we have the check or the coupon stolen in the first month, then we have got to go to another route. But again, I think our staff has used some unique ways of getting the stamps and other services to and from the clients.

One of the programs we have not talked about much today that we do differently here in the State of Mississippi is the food distribution program, and there again you have got only gasoline expenses but long, long lines of cars and people, sometimes causing traffic jams in various towns or cities while waiting to receive their food benefits. We are looking at that program as well on two counts. One is to utilize more Mississippi products in that food distribution and we have had some discussions with the Federal folks about that, and, second, to try to identify some ways to have closer distribution points so that the client does not burn up $10 worth of gas trying to get, you know, $7.50 worth of goods or whatever.

Mr. CHISM. There has been emphasis placed on the elderly not getting notification. Within the last 2½ years, since the Council on Aging has put an increased emphasis on the need for information and referral. We have learned a lot from the negotiated investment strategy I mentioned earlier.

As far as transportation to and from in the rural communities, we now mandate that our subcontractors getting our Council on Aging Older Americans Act moneys for transportation hook up with DOE funds because we do not have enough money. We can dovetail our efforts and that would improve the service somewhat.

Finally, it was mentioned to me about the weatherization for the elderly. This year, they have extended the application time for elderly above the others so that we can serve them with our weatherization before we move on to the others. The problem is we have

got 120,000 eligible households in the State and money right now to service about 4,500 a year.

Chairman LELAND. The greatest priority is placed on the Second Congressional District, as I understand.

Mr. CHISM. Most certainly.

Mr. ESPY. Well, with that, I will refrain from continued questioning.

Thank you, Mr. Chairman.

Mr. MFUME. Mr. Chairman, may I ask just one other question? It is pretty much in the form of a statement.

Mr. Commissioner, we have, those of us here on this panel, and this is putting it mildly, our hands full sometimes with members of the opposition party who argue that programs such as food stamps and other entitlement programs are not being properly used and, therefore, should no longer be funded at current levels.

And when you have a situation like you have here in Mississippi of 32 or 33 percent of the population being eligible for food stamps, 18 and 19 percent receiving them, these persons go to the Floor of the House of Representatives and hold up statistics like that and argue and argue rather convincingly to some that there is underutilization and, therefore, we should not be spending money that way.

And, so, when I mentioned earlier the need to find a way to communicate, I was not doing it in a very light-hearted fashion. I am doing it to say that unless that happens and that gap closes, not only in Mississippi but in my State of Maryland, we run the risk of seeing continued reductions in programs such as food stamps.

Baltimore was faced with action from the Federal Government for the same reasons several years ago, and the Department of Social Services had to come up with creative means quickly to find a way to reduce the gap.

Baltimore is not as spread out, but the problem was still there, and when I mentioned things about using and getting commitments from local radio and TV stations, which the Department of Social Services did there, on-going commitments that are part of their Federal requirements and falls under their licensing provisions, it is something that can make a difference.

We went to the utility companies and had them agree on a monthly basis for 12 months to mail out with monthly utility bills little small informational packets so people had information as to where to call or where to go or if you have questions who to see and whether or not you are eligible for something.

There was a partnership established between the Department of Social Services and the Inter-Denominational Ministerial Alliance, so that the ministerial alliance went out in their respective churches on Sundays to try to lessen the bureaucratic fear that many of the elderly people in my community had about going through this process, and those things cumulatively together worked over a 2-year period, so much so that the threat from the Federal Government to penalize financially the State of Maryland and specifically the area of Baltimore is now nonexistent.

And I would urge that as you go about doing what you do, as you indicated earlier, with fewer resources, that you reach for some of the creative means because it is very difficult to continue to argue

and to fight and to show reasons why we need programs like this, and we do, when there are individuals who will hold up statistics and say they are not being utilized at all, and the irony is that much of that under-utilization comes from the fact that there is a great deal of intimidation to some extent, but to a large extent, there is less and less communication to those persons who should have those services and who do use those services.

So, I would end my remarks with that, and I want to thank you for your testimony and all of you for coming here, for your sincerity. This is not a perfect Congress that we serve in, but we are trying like crazy to find ways to address problems that affect Americans, and, Mr. Armstrong, I want to agree with you since I am on record that I think that much of the money that we are sending out militarily to some of the regimes in this hemisphere and elsewhere certainly could be better used here domestically in this country.

Mr. Chairman, with that, I will conclude my remarks, and again thank the panel for their testimony.

Chairman LELAND. Let me also thank the panel for your testimony. We have consumed a lot of your time.

We have a few other questions of you, some of you, and we will submit them in writing, and if there is no objection, we will have those responses submitted for the record.

Thank you so much. Thank you very much.

Let me now ask Attorney General Pittman to come forward. I understand that he has a very brief statement, and I am going to ask that our second panel, join him as well.

Our next panel of witnesses will be Mr. Jesse Morris and Mr. C.N. Bennett. Mr. Morris helped to develop and is the present director of the Mississippi Food Distribution Program, which is based in Jackson and has been in operation since 1984. The Food Distribution Program serves the entire central area of the State.

Mr. Bennett is a retired State employee. He is with us today to discuss his personal experiences with public assistance programs and to provide us with some insight as to the difficulties many senior citizens encounter attempting to make ends meet on fixed incomes.

I thank all of you gentlemen for coming forward.

Mr. Attorney General, thank you for your presence and your testimony here today. You may proceed.

STATEMENT OF EDWIN LLOYD PITTMAN, ATTORNEY GENERAL, STATE OF MISSISSIPPI

Mr. PITTMAN. Thank you, Mr. Chairman.

I asked your staff whether or not I could submit in writing a more complete statement than I might make here.

Chairman LELAND. Without objection, you may revise and extend your remarks for the purpose of the record at this point.

Mr. PITTMAN. I was hopeful that you would do that.

I do appreciate first your presence here for what I believe to be the second time. I realize you were here in 1984. I appreciate the fact that the make-up of the committee has changed.

Chairman LELAND. I do not think your mike is projecting.

Mr. PITTMAN. I will submit a more full, more complete statement for the record, if that is convenient, for the convenience of time.

I again welcome you to Mississippi. I recognize that this is the second time this committee has met here. I would also like to recognize that the membership of the committee has changed. Congressman Espy has been added since 1984, and that is a delightful addition for Mississippi and a delightful addition for this witness, and, so, it is a pleasure to be here.

Let me just say that I think Mississippi more and more is recognizing that it cannot afford to ignore poverty or hunger. I think I recall in 1984, when this committee came here, there was some disturbance across the State of your presence and there was some concern that you might find problems. We do have problems. We recognize that. Hopefully, this society that we call Mississippi is more rapidly dealing with the problems that you have noted and the problems that we are aware of.

As a matter of fact, the hungry cannot work; they cannot learn; and they cannot contribute to the community. I do think that you have a more aggressive effort, even in 1987, than you had in 1984 from the executive branch of government to deal with these problems, maybe because of some of the work of your committee, probably because of the insistence, really, of the citizens of this State that we deal more realistically with our problems.

There are some efforts that I know you are aware of, but I would like to underscore here. The soup kitchens across the State are feeding 10,000 and more, 10,500 people a day, in dealing directly with an immediate problem. Then, of course, the School Lunch Program is excellent in its outreach and we have to recognize that, but we still are not getting to some of the root or base causes that we have. The lack of jobs, the lack of education, and the lack of opportunity. I do think the State is dealing with it a great deal better.

If I might there respond to Congressman Espy's question of why do so few who are qualified or eligible ignore the program. I think it was answered by Mr. Armstrong.

Even in my own family, I have seen a productive work habit or work ethic, but when they became Social Security retired or retired eligible for Social Security, they did not realize that they were also eligible for the other programs that we are talking about. They had been productive all of their work life and then, all of a sudden, they are qualified for shopping programs or they are qualified for food stamps. They are simply unaware because during that 35 or 40 year period of work production, they were not eligible, and they just assumed that they never would be. I think that is true in every community of this State, and we need to deal with it.

I think it is one reason that the numbers are low, Congressman Espy. We have to recognize that we have got to deal with the root problems. You talked about Rome. The main street county seat towns of this State have economic problems, and those problems reach real terms at someone's home.

I do think the State is more aggressively trying to inform the public. Your presence assists in informing the public in that you have gotten excellent coverage and that is going to help us a great deal.

The State needs to increase its cooperative attitude. I do think that is greatly improved since 1984. Congressman Espy has done a lot to allay the fears of the official community concerning your presence, concerning the desirability of the programs.

We also, from a State level, need to inventory the present effort to include soup kitchens and to find out where the gaps are. Maybe you can help us identify where we are missing, so that we can sharpen or aim a program specifically at the gap.

I heard one such problem here that I am sure is going to be attended to; the moving of the food stamp office, 30, 35, 38 miles from the person who needs those stamps. I am sure that Dr. Brittain and the official family will look at that and probably respond to that complaint. So, if the complaints are voiced, I think you will find a State government that is willing and ready to respond.

The most important thing is the fact that Mississippi no longer denies that the problem exists, and that is very, very important. Now I am talking about the official family of Mississippi.

I have read some of the reports and some of the studies that came out of the 1984 meeting. I was impressed even then that the State government was beginning to recognize what you were calling to our attention. Then I turned the page and read some reports from Alabama and, very frankly, there was a reluctance there to recognize the problems.

So, without going a great deal further, let me say your presence helps. Congressman Espy's active service and work in this community help. I think I read where he says that he has been home every weekend since he was elected. That has really helped this Second Congressional District, and has helped speak to the problems that you come here to note.

But I want you to know that criticizing or noticing a problem really is not criticizing the State, and we are coming to that realization. I will submit myself to any questions that you might have and submit a written document for the committee's record.

I would be glad to entertain questions.

Chairman LELAND. Thank you. Thank you, Mr. Attorney General.

Are there any questions of the Attorney General?

The gentleman from Pennsylvania.

Mr. KOSTMAYER. I just want to wish you good luck, and as a Yankee, I would be happy to come down here and campaign for you or against you. Whichever will be more helpful.

Mr. PITTMAN. Mr. Kostmayer, your Attorney General is a very dear friend of mine. He might be of a different party. He is a different party than mine.

Mr. KOSTMAYER. He is a different party than I am.

Mr. PITTMAN. But he is an excellent Attorney General and he has visited in Mississippi and we were delighted to have him.

Mr. KOSTMAYER. Well, I wish you would get him to visit down here more often and move down here along with all the other members of his party.

Mr. PITTMAN. As I have been informed, he is not running for reelection, Mr. Kostmayer. Maybe that will make you feel better.

Mr. KOSTMAYER. Well, if I can help, let me know.

Mr. PITTMAN. You are very kind. The most important thing is that your presence helps the State.

Mr. KOSTMAYER. Well, we are honored to be here.

Mr. PITTMAN. Mr. Chairman, you know, the advent of the other party is somewhat late in Mississippi but it joined me at the beginning of my career in 1963. They showed up and they have haunted me ever since, but so far we have been able to survive.

Chairman LELAND. Well, they haunt us in Washington, too. We are thankful to have retrieved the leadership in the Senate and we secured a stronger majority in the House of Representatives. With regard to Mississippi, the addition of Mr. Espy here is most welcome by the leadership of the House of Representatives.

Mr. PITTMAN. I think I remember that there were only maybe five congressmen of the other party that were defeated and we are very pleased that Mike was one of those successful people. It has really been very, very good for the second district. His willingness to walk the streets of this district, shake hands, visit with people and ask them about their problems and directly connect the citizens, frankly, with the Federal establishment has been more helpful maybe than you would even recognize or realize. I am not here just passing out apples or gold stars for Mike Espy.

I have done that in my career, but the truth is that there is a noticeable difference. There is an improvement in governmental services. There is an improvement in hope in this second district.

Chairman LELAND. Very good. Are there any other questions of the Attorney General? [No response.]

Mr. Attorney General, thank you so much for your participation and your contribution. [Applause.]

Now, we will hear from Mr. Jesse Morris.

Mr. Morris.

STATEMENT OF JESSE MORRIS, DIRECTOR, MISSISSIPPI FOOD NETWORK

Mr. MORRIS. Thank you for this opportunity you are giving me to share my thoughts with you.

I do direct the food bank, a statewide food bank, that covers the central area of the State. A food bank, as you know, is an organization that contributes food to charities and these charities in turn give it to individuals.

I do not want to talk much about the food bank in my prepared remarks. I can do that when you ask me questions. I want to make a policy recommendation, and that policy recommendation is this: the Congress should direct the governmental agency to perform a comprehensive and detailed area-specific nutrition survey of the U.S. population and require that agency to develop and maintain some form of on-going surveillance.

I am trying to say that we need to know the extent of hunger in the country and we do not know that. I think that if a listing in order of priority of those things that need to be accomplished in order to eliminate hunger in this country was drawn up, we would find this policy recommendation at the top of that list.

Public policy directed toward solving a problem cannot be adequately developed, implemented or targeted in the most effective

manner if a complete understanding of the problem that is being faced is not properly understood.

The problem of hunger in this country is not properly understood and there is nothing more clearly that points that out as this headline in the morning's Memphis paper, talking about this committee, where it says, "Diverse Views to Greet Panel on Hunger," where one panelist says there is no hunger problem in the country and another says there is.

There is not a consensus in the country that there is a hunger problem. The problem of hunger in this country is not properly understood because the information and data necessary to properly understand the problem has not yet been put forth. The problem of hunger in the United States is a problem that currently seems to defy acceptable measurement techniques. It seems that the most we can say is that there are a lot of hungry people out there, but that really does not tell us anything.

It does not convince the people who do not think there is a problem or those who just do not know. As Mr. Penny said earlier, he would like to see his colleagues come down and see what he has seen this morning because some of them just cannot believe it. There are some people that are not going to believe anything until they see it.

One of the questions that needs to be asked is why are we having and why do we continue to have these types of hearings. What service do they perform. It is clear that they do focus attention on the problem of hunger for a brief few moments, through, of course, the media coverage regarding the fact that the hearings are taking place. We shall see that there are a large number of people concerned about the problem of hunger. We shall see there is a considerable private effort being undertaken to assist those who are hungry.

We shall hear all the statistics relating to poor people, unemployment, food stamps, health and medical information, and a long litany that is supposed to show the extent of hunger that exists, and then we shall hear the horror stories of what Ed Meese calls the anecdotal accounts of hunger.

What we will not get out of these hearings is any information on the extent of hunger or malnutrition by medical or clinical definitions. We never come to any meaningful conclusions about how widespread hunger is or where it exists.

For example, is there more hunger in this county, say Leflore, than there is in the adjacent county, and if there is more or less, how much more or less.

These are questions we cannot answer, and until we are able to answer them, we are not going to be able to effectively eliminate the problem. The inability on the parts of those who are most concerned with the problem of hunger in the country to devise, after all these years, a quantifiable measurement tool to describe the problem contributes in part, I feel, to the persistence of the problem.

Before the problem of hunger can be eliminated, it has to be recognized as a problem by the vast majority of people in the country, not just a few concerned congressmen or hunger advocates or those who work in soup kitchens, food pantries or food banks.

The real problem is that they have not been able to convince the rest of the country that there is a problem. Of course, it should be more in mind that in most cases documenting the existence of hunger is not one of their responsibilities.

One would think that the Census Bureau or some other Government agency would have long ago been mandated by the Congress to develop a means to measure the extent of hunger in the United States on a regular and frequent basis. The President's Task Force on Hunger, which was put together by Ronald Reagan a few years ago, for the purpose of assessing the hunger problem, in a final report to the President concluded:

> * * * since general claims of widespread hunger can neither be positively refuted or definitively proved, it is likely that hunger will remain an issue on our national policy agenda for an indefinite future.

One way to interpret this or one way I interpret this, it seems to me it is saying we cannot do anything about hunger until we can prove it exists, and since we cannot prove it exists, we cannot do anything about it. Unfortunately, that is the thinking and the attitude expressed by many in Washington and throughout the country.

The Census Bureau has a slogan. It reads, "We can't know where we're going if we don't know where we are." And clearly those of us concerned with the problem of hunger are going to have to realize that we are not going to see this problem eliminated until it can be shown irrefutably that it does exist.

Therefore, I believe the first order of business is to somehow implement the policy recommendation.

Thank you.

Chairman LELAND. Thank you very much.

Mr. Bennett.

STATEMENT OF C.N. BENNETT, YAZOO CITY, MS

Mr. BENNETT. I want to thank you for allowing me this opportunity to tell you about my living situation and how I am affected by the Food Stamp Program. I am a retired State employee. I retired 10 years ago. I live with my disabled wife. Our only income is from social security. I receive $462 a month and my wife $182. Together, my wife and I have a total of $644 a month.

My wife and I are both ill and require quite a bit of medicine each month. Our medicine, prescriptions, and nonprescriptions cost approximately $125 a month. My other living expenses are house rent, $75, rural insurance on the house, $48 a month, National Senior Citizens Hospitalization, $51.50 a month, public service commission lights and water, $94.22, Mississippi Valley Gas, $100, telephone bill, $40, New York Life, $15.20. This totals $464. Medication, a $125 a month. That is $589.

As you can see by this time, I pay the bills and buy medicine each month. I only have $54.20 left to buy gas for transportation and other personal items my wife and I may need. It is very seldom that I buy anything other than food with the $54.20 because I only get $38 a month in food stamps. Believe me you cannot do very much at the grocery store with $38.

I do not have any children that I could get help from, and my wife is too ill to leave alone for a very long time. Today, I had to ask someone to stay with her so I could come up here. My problem was worse before I went to see Congressman Espy and got some help with the cost of my wife and my medicine through the county health department.

I am 75 years old and have worked hard almost all my life and paid taxes. Now that I need some help, I am always told I cannot get any because of my income. I wish someone would tell me how a person is to make it 5 years from now if everything goes up, costs going up more and more each year.

The elderly people here in Mississippi need some help with their medical needs and food. It seems as no concern about how the old people will get along.

I appreciate you all listening to my position.

[The prepared statement of Mr. Bennett appears at the conclusion of the hearing, see p. 205.]

Chairman LELAND. Thank you very much, Mr. Bennett, for your compelling testimony.

We really appreciate your coming before the committee today. Let me say that when we hear from private citizens, we tend to appreciate even more so than many of those who are the advocates or who are the administrators because we know that it takes a lot for you to come forward to discuss your personal situation. In your case we appreciate especially, the time you spent away from your wife today, to come and tell us your story.

Let me promise you that your story helps us tremendously when we are reporting to the Congress and to the administration the problems that are exacerbated by the insensitivity sometimes and the lack of resources that we tend not to provide.

So, thank you so very much. I know that I echo the sentiments of my colleagues here, too.

Before I get to you, Mr. Bennett, let me talk to Mr. Morris to ask him just a few questions.

To how many agencies does your organization distribute food, Mr. Morris?

Mr. MORRIS. We serve food to 128 agencies, which we call member agencies, soup kitchens, food pantries, day care centers, domestic violence shelters, children's homes and the like.

Chairman LELAND. How does that compare to the number that you distributed food to 2 years ago?

Mr. MORRIS. Two years ago, we had about 40 agencies, 30 or 40.

Chairman LELAND. So, you are growing in agencies that you are able to serve.

Mr. MORRIS. We are growing, you know, over time. I think that comes from—I do not know what that says about hunger. I think that food banks just naturally grow. They expand out. More and more people see they exist, they want to form more food pantries to give to people, but the same amount of hunger might have been there, it is just being taken care of a little better.

Chairman LELAND. Are you finding more and more contributions to your efforts on the part of the private citizens?

Mr. MORRIS. Yes. The contributions, last year, we received—our first year, we received 200,000 pounds of food.

Chairman LELAND. How many?

Mr. MORRIS. 200,000.

Chairman LELAND. 200,000.

Mr. MORRIS. Last year, we received, the second year, 500,000. Third year, 700,000. This year, we will take in over 1 million pounds of food that is all donated.

Chairman LELAND. What factors prompted your establishment of the food bank?

Mr. MORRIS. Well, the food bank actually came out of the efforts of people that had food pantries in existence already, and they saw that it was better to have one source raising food for them, so they could save their resources for going to other things.

Of course, food bank is something that started some 20 years ago in Phoenix, and it is an idea that just kind of spread across the country. So, these pantries saw what was happening in other places where there were food banks and said, look, it makes sense to have one here in Mississippi.

Chairman LELAND. You used to distribute the surplus food commodities.

Mr. MORRIS. Yes, we did.

Chairman LELAND. But you terminated that program.

Mr. MORRIS. We terminated it because the amount of the administrative money that was available to enable us to do it kept falling down, and it got to the point where it was costing us too much to do it.

The reason we did the food stamp—I mean——

Chairman LELAND. Can you turn the mike just a little bit?

Mr. MORRIS. The reason we engaged in getting out the commodities, and I want to allude to something that Dr. Brittain said, in Jackson, which is the largest city in the State, there are some 12 or 14,000 people that are eligible for the commodities.

The distribution takes place in 1 day. That means you have 12 or 14,000 people that line up for that day, some as many—some as long as 3 or 4 hours waiting to get the commodities.

In addition to that, they come from all over the county, and there are some areas in the county where there is a round-trip ride to come to Jackson to get the commodities.

What we wanted to do was set up a system where the people did not have to come to Jackson if they lived in a town like Utica or Bolton or Raymond or Terre Edwards, but set up a little site where they could get their commodities there.

We also wanted to cut down on these lines. So, we set the distribution problem—I mean, the distribution over a 14-day period. Where people had been standing in line for 3 and 4 hours, nobody ever stood in line at one of our distributions for more than 3 minutes. We were paid or compensated on the basis on the value of the product, and the value kept going down because the product mix would change. Instead of giving out butter and cheese, we were giving out flour and powdered milk, which has a much lesser value.

The most the welfare department ever distributed commodities to——

Chairman LELAND. Excuse me. Mr. Morris, let me understand. You were being paid according to what you distributed?

Mr. MORRIS. Yes. When the program first started, the Federal Government gave the States 6 percent of the value of the product. OK. The total value of the product to the State was a—excuse me. The total value—the money that the State got for the distribution was close to $1 million. All right. That was 6 percent of the total value of all the products given out.

So, when we got a quantity of products, the value of that was looked at and then we got a percentage of that, but when you changed the mix of the products, from cheese to flour, from butter to powdered milk, you dropped the value of the product.

Chairman LELAND. So, the 6 percent shrank?

Mr. MORRIS. Right.

Chairman LELAND. Not that the actual dollars shrank.

Mr. MORRIS. So, for that reason, we had to stop the distribution. I might also add that the most that the welfare department ever did in this distribution was 12,000 people. We were doing up to 14, almost 15,000 people because they had greater access. The people from the outlying areas were able to get in and the elderly people could come because they did not have to stand in line for 3 and 4 hours, you know, only 2 or 3 minutes.

But that money—now, we met with the welfare department, I did, and two of my board members, last Thursday. No, I am sorry. Wednesday. Just the day before yesterday. We talked to them again about doing the distribution. They told us the administrative money had come down to $4,000. We might still try to do it anyway, but that is one thing the—I hear the Congress has appropriated the money for the program, but somehow it does not get to the States. I do not know why that is.

Food banks are a much better—I mean, they are equipped to distribute to, they are equipped to handle it, the welfare departments are not equipped to handle it, and they do it, they use case workers to do it when they should be handling their cases and that kind of thing.

Chairman LELAND. When this committee visited Mississippi in 1984, we received testimony that current guidelines for the Commodities Distribution Program were not responsive to the conditions in rural areas. What program revision would you suggest for improving and expanding the commodity distribution in rural areas?

Mr. MORRIS. How do you mean?

Chairman LELAND. Or do you agree with the premise——

Mr. MORRIS. Say the premise again.

Chairman LELAND. The premise is that the distribution program itself is not necessarily as responsive to rural areas as it should be.

Mr. MORRIS. Well, quite frankly, most of the programs that exist for dealing with social problems, really we find less access to them than people in metropolitan areas. Rural people are kind of the poorest of the poor, and the most neglected when it comes to getting services.

Access has a lot to do with that. Transportation to and from the larger areas where you have to take advantage of it, where you get the services or fill out the applications. Those things are just kind of denied rural people and we somehow have to find out how we can get our delivery system to meet the rural folk.

That is a problem that I think are social problems.

Chairman LELAND. Yes. I understand. Let me say one last thing about the issue of identifying hunger in our country. I agree with you that we have not yet defined hunger nor have we been able to identify the quantity of hunger—the depth of hunger in our country.

We are making several attempts to do so through congressional actions, one of which was a measure that I sponsored with a few of the members of the Select Committee on Hunger a couple of years ago. We looked at the possibility of requiring that malnutrition be reported to the Center for Disease Control in Atlanta as a reportable disease. In our research we learned it was more feasible to conduct pilot projects on monitoring and reporting severe under nutrition among children. We are currently awaiting an announcement as to the recipients of these grants. I think Mississippi applied for one of these grants.

I do not know yet whether Mississippi was successful in obtaining some of the funds for that purpose, but you are absolutely correct that we do not know the extent of hunger. We have worked with doctors here who participated with the Physicians with a Conscience and the Physicians Task Force on Hunger in America who have been trying desperately to gather statistics on hunger around the country, both in rural and urban communities. However, we have not yet put into place an official system for quantifying hunger. I think, or at least hope, that the embarrassment of the conditions being discovered these days will help us move forward in this quest. In the city of Houston, in my own district, the estimated number of hungry people is around 400,000.

I said that to a city councilman the other day, who happened to be black, and he was absolutely flabbergasted. He said, "How can that be? We only have 1.8 million people," and I said, "then, recognize the magnitude of the problem." Therefore, we need some means to gauge, identify, define, and report hunger so that we can begin to cure the problem.

I want to thank both of you.

Let me just yield to my colleagues and then maybe come back to you.

The gentleman from Pennsylvania.

Mr. KOSTMAYER. Mr. Bennett, may I ask where do you live, sir?

Mr. BENNETT. I live in Yazoo City.

Mr. KOSTMAYER. Yazoo City. Do you live in the town or out in the country?

Mr. BENNETT. I live in town.

Mr. KOSTMAYER. In town. What did you do for the State? What kind of work did you do?

Mr. BENNETT. I worked on this flying program, distributing over the State of Mississippi.

Mr. KOSTMAYER. I see, sir. How long did you work for the State?

Mr. BENNETT. Seven and a half years, not long enough to draw any pension.

Mr. KOSTMAYER. Not long enough to draw a pension. What did you do before you worked for the State?

Mr. BENNETT. I farmed 40 years. I have had a sick wife for 30 years. When I sold my farm house, she was in the hospital for 19

weeks. Consequently, I owned a home at that time, and I had to sell the home to pay the hospital bill. That is the reason I am having to meet house payments now, and I got a loan through the Farmers Home Administration, is the only reason all I am paying is $75 a month payments. If I was having to rent a house, I could not rent one like I got for less than $250–$300 a month.

Mr. KOSTMAYER. But you were a farmer for 40 years?

Mr. BENNETT. Yes, sir.

Mr. KOSTMAYER. I see. Now, you said that you get about $38 in food stamps and that is in addition to the $54.20 you have left over after you have paid your bills?

Mr. BENNETT. Right.

Mr. KOSTMAYER. So, you have for food $54.20 plus $38, you have got to buy your food with that, plus any gasoline or anything else.

Mr. BENNETT. Right.

Mr. KOSTMAYER. And how much do you actually get to spend on food a month for you and your wife? What does it come to? You have the $38 in food stamps. Do you also spend some of that cash on food as well?

Mr. BENNETT. Yes, sir.

Mr. KOSTMAYER. About how much of it? Do you know offhand?

Mr. BENNETT. Well, if it was not for us putting up some vegetables and things, I would spend it all, and if it was not for canning some vegetables and putting them in the deep freeze, this, that and the other, I would be on starvation.

Mr. KOSTMAYER. Do you have a vegetable garden?

Mr. BENNETT. No, sir. But I buy a few vegetables and have some neighbors that I used to have on the farm to bring me vegetables and things like that.

Mr. KOSTMAYER. Let me ask you, without meaning to embarrass you, if I can, do you actually find that when it comes to eating, you and your wife have to do without? I do not mean without any food at all, but that you might have a bigger meal if you could or eat more frequently or how does it affect you—would you say you get three pretty good meals a day?

Mr. BENNETT. Yes. Of course, we used to eat a lot of meat. We do not now because meat is too high to buy. We more or less are vegetable eaters.

Mr. KOSTMAYER. Well, that is good.

Mr. BENNETT. Yes.

Mr. KOSTMAYER. Should not be eating all that meat anyway.

Mr. BENNETT. Yes. I reckon that is right.

Mr. KOSTMAYER. Except once in awhile. Not too often, though.

Mr. BENNETT. Yeah.

Mr. KOSTMAYER. All right. Well, I appreciate your coming here and I appreciate your testimony.

Mr. BENNETT. Well, I want to commend Mr. Espy for helping me get some assistance on medicine. That has been the main thing, and I paid in some money one time, I forget what you call it now, workman's compensation. That is what it was, and I went to the agency that I was supposed to have gotten some money for unemployment, you know, when I was not able to work, and they said my check was too big. Everywhere I go, I try to get SSI, and they said our check was too big. Well, I do not see how anybody could

figure $600 and some a month with the expenses I have that has got to be paid, I mean, you have got to have lights and water and gas and some groceries, and I do not see how they could say the check is too big, but that is what they said. All I could do is accept it.

Congressman Espy got me some assistance through the county welfare department to help on the medicine. Of course, she still takes a lot of medicine that they do not help you on, and it is the most expensive part, but thank God I got some assistance anyway.

Mr. KOSTMAYER. Earlier this week, in the Congress, at least in the House, we passed some legislation which, if the Senate passes, and I do not know whether they will, will help you and Mrs. Bennett with your prescription drugs and help you to pay for some of those prescription drugs.

Now, of course, Reagan says he is going to veto it. I hope that he does not. Maybe he will forget he said he would veto it.

Mr. BENNETT. I hope he does. I have got the red, white, and blue card, but it is still saying my checks are too big to get the yellow card where it pays the doctor bill and the other. Everywhere I go, my check is too big.

Mr. KOSTMAYER. Well, I do not know how you keep track of all those cards, but let me just say, Mr. Bennett, in conclusion, that I appreciate your commending Congressman Espy and let me say what he probably cannot say, do not just commend him but vote for him, too, when the time comes.

Mr. BENNETT. I did before. I appreciate y'alls time.

Mr. KOSTMAYER. Yes, sir.

Chairman LELAND. Mr. Mfume.

Mr. MFUME. No questions.

Chairman LELAND. Mr. Flake.

Mr. FLAKE. No questions.

Chairman LELAND. Mr. Penny.

Mr. PENNY. No questions.

Chairman LELAND. Mr. Espy.

Mr. ESPY. Just a couple of observations, Mr. Chairman.

First, to Mr. Bennett. I want to thank you for the praise that you heaped upon me, but, honestly, I am just doing what I am supposed to do. So, I will just let it go at that. I really appreciate your coming.

Mr. BENNETT. You are the only one that would ever do anything for me.

Mr. ESPY. Well, thank you, sir. I appreciate that.

We were in Rome this morning, and I had a chance to talk with a woman there, she told me something I found really, really shocking. She says that during the first of the month, when she receives her food stamps, the merchants in the area, and I am, of course, not going to name which stores, but she says that they have a tendency to raise food prices right around the time that the folks are supposed to receive their food stamps.

Now, from your personal experience, is this true or is this untrue?

Mr. BENNETT. I think it is true right here in Yazoo City. Right here in the city where you were born and raised.

Mr. ESPY. So, you get your check right around the first of the month, second or third, and you notice an appreciable increase in food prices and then the next week, let us say, you are going back and the prices on those same items will be reduced?

Mr. BENNETT. That is exactly right. You can buy the same item right in Jackson, MI, for a whole lot less than you can in Yazoo City. Of course, it is not feasible to drive to Jackson, 40 miles, 80 miles, to save a few dollars, but they have got a monopoly on the grocery business in Yazoo City.

Mr. ESPY. I am not talking about Jackson now as opposed to Yazoo City because some would argue that transportation costs in rural areas, you know, are a little bit more difficult and, therefore, it is more incumbent upon the retailers to raise it. I am asking you because there are folks receiving food stamps in Jackson. So, I do not want to compare Jackson with Yazoo City.

I am asking you, in Yazoo City and in Jackson and in Rome and in places around, you have noticed an increase in food prices around the time——

Mr. BENNETT. Right, right.

Mr. ESPY. Mr. Chairman, that is sickening to me. That is sickening to me, and I personally am going to do my best to do something about that next week. OK. I will bring that to somebody's attention.

Mr. Morris, I appreciate your testimony as well as yours, Mr. Bennett.

I noticed in your testimony, you talked about the obstacles in delivering, obstacles in the food distribution system, and I gather from your testimony that transportation and regional sites seem to be a pretty serious barrier to distribution of food stuff.

Is this the primary obstacle? Is the transportation to the—of the food recipient to——

Mr. MORRIS. You are talking about the TF products?

Mr. ESPY. Yes.

Mr. MORRIS. I do not know how the system works in other counties outside of Hines County and Jackson, but I would assume that in most places, people have to come to one central location, and when you have a county like Sunflower, which might exist 50 or 60 miles, that means people are going 100 miles round trip for $10 or $12 dollars worth of commodities.

I think that the system could be more effective and will be better served for the people if you had six or seven sites in each county.

Mr. ESPY. Six or seven sites.

Mr. MORRIS. Six or seven distribution sites in most of the counties, and in an average-sized Mississippi county, six or seven distribution sites would be what is necessary.

Mr. ESPY. I see. And, again, this may—something also disturbing, the fact that you decided to quit the job of distributing food, was the fact, you know, that the fee that you received kept lowering, kept becoming lower.

How is it now? Is it still 6 percent of the value of the food stuffs distributed? Is that still it? I mean, that is not your fault.

Mr. MORRIS. No, but the Federal Government is giving much less money than they were giving 4 years ago. I think money has been appropriated, as I said before, but I do not think it reaches the

States. I do not know why that is, but I know there is no administration money for the distribution, for the people that do the distributions.

So, the welfare department mainly underwrite that cost themselves.

Mr. ESPY. OK. Thank you. Thank you, sir. I appreciate it, Mr. Chairman.

Chairman LELAND. Thank you.

Mr. Bennett, how long were you a State employee?

Mr. BENNETT. Seven and a half years.

Chairman LELAND. How many?

Mr. BENNETT. Seven and a half.

Chairman LELAND. Seven and a half. What did you do before you were a state employee?

Mr. BENNETT. I farmed all my life.

Chairman LELAND. Why did you stop farming?

Mr. BENNETT. Well, I was leasing a good deal of land and they started bidding the land just like they do in school sections and they run the rent up and I was 55 years old at the time, and when I sold out, I had enough money, I thought, to live on the rest of my life.

In 1970, my wife went in the hospital and had a serious operation and I had moved to town and bought me a nice home, and I lived in it 6 years and had to sell it to pay the hospital and doctor bill, and I rented places from year to year for about 3 years and finally I got a loan through the Farmers Home Administration to buy a house, and the payments are based on your earnings, and I am only paying $75 a month payments on it.

Of course, I have to pay insurance and have to maintain the house, but if I was renting such a house as I am living in, it would cost me anywhere from $200 to $300 a month rent.

Consequently, I am doing pretty good, but my money that I should have had to live on now and not been trying to get food stamps or anything else went for doctor bills to save my wife which is 1970 and that is 17 years ago, and I do not know how I would have got along without her.

Chairman LELAND. Well, we certainly appreciate your testimony. It seems to me that a former State employee and a person who was paying taxes on the revenues that you were earning as a farmer should facilitate an opportunity for you to live comfortably in your later years when you have to retire and take care of your wife.

We on this committee are trying desperately to drive that home as best as we can to the Members of Congress who we serve with and to the administration and power, whichever administration that might be, to continue to try to eliminate the problem by testimony like yours and also like Mr. Morris' and those others who have come before you today and who will testify after you.

I cannot—I am sorry.

Mr. BENNETT. The rules and regulations. I even went to the State office in Jackson to see if I could not get some kind of assistance, SSI or something like that, and the rules they have, they tell me, is by the legislature, not through the Federal Government, that the only way you can get SSI with the amount of money I am drawing

is for my wife to be in a nursing home or having minor children or some such something as that.

I went to Mr. Simmons himself, which is the head of the thing in Jackson, and he just flatly told me there was not any way I could get any SSI or anything else. My check was too big. That sounds like everywhere I go. My check is too big.

Chairman LELAND. Let me ask you something. If you put your wife in a nursing home, you can get more—they will raise the amount of your benefits or put you on SSI, is that correct?

Mr. BENNETT. That is the way he said it, in a way.

Chairman LELAND. That is criminal. So, the effect is that it is more of an incentive for you to put your wife in a nursing home rather than keeping her home close to you.

Mr. BENNETT. Right. Right.

Chairman LELAND. That is incredible.

Mr. BENNETT. He indicated that, in other words, I had one of the fellows in the legislature to look up and he said it was passed by the legislature. I do not know whether that is the Federal doings or what about this SSI deal.

Chairman LELAND. Well, let me, for the purpose of the record, ask unanimous consent that we get some clarification about those circumstances for the record. I will ask the staff to please find that out and enter it into the record in response to the issue raised by Mr. Bennett.

Mr. BENNETT. Yes.

Chairman LELAND. Mr. Bennett, I just want to say thank you very much. You have been very helpful. The testimony provided by both you and Mr. Morris is invaluable to us.

Thank you so much, and we wish your wife well.

Mr. BENNETT. Well, I have reached the last resort and I am glad to be able to talk to you all and appreciate your all coming down here and trying to help us people.

Chairman LELAND. Thank you so much. Thank you. [Applause.]

Mr. ESPY. Thank you, Mr. Chairman.

You gave me an idea. I am still concerned about this problem of increasing food prices a couple of days per month, and I suppose before I go off half-cocked, I guess we should undertake some research. So, I would like to have unanimous consent to ask staff, if we could, Mr. Chairman, to see whether this is a problem indigenous to Mississippi or if this is a national problem, this is an occurrence around the country, and we will take according measures.

Chairman LELAND. Very good. Without objection, so ordered.

I would now like to call forth our final panel of witnesses, and let me say I really appreciate your patience. I know that it has been a long day. Let me also advise that the members of the committee, including the gentleman from Mississippi, are going to have to rush to get to airplanes in order that they go to different places around the country and some of us, namely me, has to go and leave, and I am going to leave to go to Rome and not Rome, MS, but rather Rome, Italy, tonight by way of Memphis, Dallas, Frankfort, Munich, and Rome.

So, let me thank you for your patience. Your coming here last does not mean that you are certainly the least.

We have Dr. Cobb, who is a diplomat of the American Board of Preventive Medicine and Public Health. He has been with the State of Mississippi Public Health Department for close to 30 years, during which time he has served as the executive director of Comprehensive Health Planning Board, the executive director of the Mississippi Medicaid Commission, and since 1973 as the State's health officer.

Dr. Cobb is accompanied today by Dr. Alfio Rausa, director of the Leflore County Health Department.

We have Ms. Agnes Hinton, who is a registered dietician and licensed nutritionist. She is currently the nutrition service director for the Mississippi Department of Health, and we have Sister/Doctor or Doctor/Sister Anne Brooks, who accompanied us to Rome this morning, who is a Catholic nun of the Sisters of the Holy Name of Jesus and Mary.

In 1983, she completed her training as an osteopath. That year, she moved to Tutwiler, MS, where she has been serving as a physician in the local clinic, and as I understand it, she is with the National Health Corps. She is retiring from the National Health Corps soon, but because of the work that she is doing in Tutwiler, after her retirement from the Public Health Service, she is going to stay here.

Our commendations to you, and I understand she is also on vacation this week and, unfortunately, we have put her to work, and we want to thank you very much for such a great visit that we had this morning.

Dr. Cobb, you may proceed.

STATEMENT OF ALTON B. COBB, M.D., STATE HEALTH OFFICER, MISSISSIPPI DEPARTMENT OF HEALTH, ACCOMPANIED BY ALFIO RAUSA, M.D., DIRECTOR DELTA/HILLS PUBLIC HEALTH DISTRICT

Dr. COBB. Thank you, Mr. Chairman.

It is certainly a pleasure to be here and to share this with two of our staff members, namely Dr. Brooks. I have read about her work. I think this is the first opportunity I have had to share an occasion like this with her and I appreciate this.

As I understood, you asked that we might make a few comments about our infant mortality rate and some of the improvements we have made in that area, and then see if we could tie that together with some of the other conditions and programs in which you may be interested.

As we all know, Mississippi has traditionally had the highest infant mortality rate in the country. To cite the statistics, in 1983, our rate was 15.3 per thousand live births, and by 1986, that had dropped to 12.3. So, that is a drop of almost 20 percent in that period of time.

We are proud of that. We are no longer No. 1, and I am not here to cast stones at those States that exceed us slightly now, but South Carolina and Alabama have rates a little bit higher than ours.

We all know that the problem of high infant mortality is a very complex problem. The solutions, therefore, are somewhat complex

themselves. There are numerous contributing factors to the problem, with inter-relationships complicating the assessment of the problem and evaluation of the interventions.

The reduction in infant mortality experienced in this State is undoubtedly the result of concurrent improvements in several areas, accomplished through the enduring efforts of many organizations, agencies and individuals, both public and private.

I want to particularly emphasize that point. I happen on occasion to have the pleasure of announcing our improvements in this particular index, and we take pride in that, but we certainly do not pretend to say that it is the State health department, the county health departments, or the public health system alone. It is a combined effort of the private and public sectors and a lot of different activities going on in our State addressing this.

We know that this problem is related very closely to our socioeconomic and demographic characteristics, namely those, as you have discussed here today, of poverty, our rural population, low educational levels and high unemployment.

We are, of course, having the problem that since these indicators prevail in this State, we do not have the resources which many other States do to attempt on a State level to address these problems. But we have taken our resources and tried to target them in the very most effective way that we could.

This last year, the Governor's Infant Mortality Task Force asked our department to develop a 4-year plan to try to improve upon the infant mortality in Mississippi. This plan involved four elements: (1) Prevention of unintended pregnancies, particularly toward lowering our teen birth rate; (2) comprehensive prenatal care, making it available to all of our mothers in this State and trying to make that high-quality care integrated with our WIC Program and with other programs of the State; (3) access to maternity, infant and preventive health services statewide; and, finally, (4) continued regionalization of our pernatal services from our tertiary center in Jackson at the University Medical Center out to our second level centers that are scattered around over the State.

We presented this plan to the Mississippi legislature during its 1987 session. I am pleased to inform you that we received full funding to implement the Medicaid expansion as was authorized by the Congress. I am very impressed with the authority which you provided in that particular legislation because it permits a State to target a particular Medicaid benefit to a high-risk population in which we can apply the interventions in the most effective fashion possible.

As you know, this Medicaid expansion allowed Mississippi and other States to cover pregnant women with a family income up to 100 percent of the Federal poverty level, and to cover their infants and children up to age 5. I am very pleased that our State fully implemented that benefit. We were one of the first States to do so. The legislature appropriated the additional funds needed for this expansion.

This expansion will be phased in beginning October 1 of this year. It starts with coverage of pregnant women and infants in fiscal year 1988. The State had previously implemented an optional

categorically needed program in 1985, and expanded the standards of need for Medicaid and AFDC to 50 percent of poverty in 1986.

So, this was just one of several steps that our State has made in an effort to try to improve access to care for this particular high-risk population.

These combined efforts are expected to provide coverage for at least 7,000 pregnant women and 46,000 children in this State when fully implemented.

Let me point out that at that point that about one-half of all of the deliveries in this State will be covered on the Medicaid Program, which will certainly be of considerable help in assuring access for low-income population to delivery services.

The 1987 legislature also gave the State Department of Health authorization to coordinate the development of a regionalized system of pernatal care and appropriated an additional $100,000 to supplement the $150,000 already available to us in State funds for newborn transport system as a part of that regionalized system.

We are going to ask at the next session for additional funds to upgrade care in our second level and first level centers all across our State. We have about 100 hospitals in this State that deliver babies. We are now assessing their needs, and we will address that in the next session of the legislature.

This very positive response of the State legislature to the plan is very encouraging to us. However, the State could not afford to fund some of the other initiatives, including additional funds for our high-risk maternity program. For several years, we have operated a program using some maternal and child health block grant funds and some State funds to purchase care for high-risk mothers who need care in a second level center or in the tertiary center at our medical school.

There, we try to target and make sure that at least the high-risk mothers, those who have risk factors, are able to be admitted to and be cared for at an appropriate level of care, not just in any hospital, but a hospital that is appropriately staffed to provide the level of care which they need.

As has already been mentioned, the legislature also authorized a school nurse intervention program, a targeted-type of school nurse effort. We all know that we have had school nurses in our country for years and years. However, in this instance, we are trying to train these nurses especially for intervention with junior high school age children and those in the first part of the high school years to provide group instruction and individual counseling, in an effort to improve self-esteem and to intervene in ways that we believe, and we have shown in some pilot projects, can be effective in lowering teen pregnancy rates in our State.

While we are discussing teen pregnancy, let me just move from my prepared remarks to say that our teen pregnancy rate is not any higher than a number of other States. As a matter of fact, according to the Guttmacher studies, our race specific teen pregnancy rates are about average for the country.

Our teen birth rate is a good bit higher. It is the highest in the Nation. It is not a lot higher than several other States, as a matter of fact, and it is declining. The difference is that the incidence of abortion is very low in our State.

So, it is because of the value systems of our people and the attitudes of our people that they do not utilize abortions to intervene and therefore lower the teen birth rate.

We believe that the best intervention is early intervention through education, counseling, and family planning services, and that is our strategy.

We will fund this next year more than 20 school nurses in this special initiative. Several of those are funded through the Governors' office through the social services block grant that Mr. Chism has already described. Some will be funded through title X of the family planning funds, and we will use some maternal and child health block grant funds.

Let me say this, from the supplemental appropriation you just passed for the maternal and child health care block grant, we will receive about $300,000 and we will use a good part of that money to fund some of these additional nurses will be in our high-risk schools this next year.

The State of Mississippi has chosen to utilize maternal and child health block grant funds to provide access to prenatal care and delivery services for low-income women. Through the statewide network of county health departments, more than 16,000 women in this State receive their prenatal care through the health department system.

I want to emphasize this to you, gentlemen, particularly to those of you other than Mr. Espy who are from other parts of the country, to help you understand that in the Southeast and in some other areas of our country, the health departments are very much involved in actual delivery of health care.

In some areas of our country, they are not as involved. They are more involved in terms of setting standards and providing education, but here in the Deep South, health departments have traditionally been heavily involved in primary care.

The primary care in which we are involved is somewhat targeted along the lines of preventive services, such as family planning and maternity, and we do provide some hypertension services and other services. I think Mr. Bennett made reference to one of our programs where he said he was receiving assistance with some of his drugs.

Let me turn to the WIC Program. We operate the WIC Program in Mississippi differently from any other State, and you, I am sure, have already heard this, but we have a direct distribution method of administration in which we actually purchase the foods on contract, through bids, and operate a network of miniwarehouses over the State and make these foods available directly to the eligible persons through those warehouses.

We serve, as a result of the efficiencies of that system, 60 percent of the estimated eligibles. The average for the Nation is about 40 percent. We are by far serving the highest percentage of eligibles in the WIC Program than any other State in the Nation, and I think it is, frankly, mainly due to the fact that we have targeted the funds through the direct distribution system, and we are able to achieve some economies there.

Illustrating that, we are now paying 61 cents a can for infant formula for 1988. If any of you have infants and you are buying for-

mula, I think you know that the going rate in the stores is about $1.40.

Even when we add in all of our distribution costs, we still have the lowest cost per month of serving a WIC client of any State in this region, and I think we are one of the lowest, if not the lowest, in the Nation. We could not, of course, meet the tremendous need for the WIC Program without Federal assistance.

We would like to provide similar nutritional services to the elderly population. We did apply for special waiver under the Commodities Supplemental Food Program to see if we could not offer that program in a few of our counties.

Frankly, as I understood it, we were turned down because they said we were doing such a good job with WIC and serving such a high percent of the eligibles, they could not qualify us for a waiver. It seems odd that when you do well with a program, you get penalized when you would like to do something for a different population group.

Mr. ESPY. Is that not ironic?

Dr. COBB. Mr. Espy, I believe that was the response that we received from our inquiry. We did apply through the Governor's office, in cooperation with the Governor's office.

Moving on, and I know the hours are passing on, we are going to recommend to the next session of the legislature that it implement the next phase of Medicaid expansion and that is to expand Medicaid to the elderly with incomes up to 100 percent of Federal poverty, and you know that would really help Mr. Bennett. That would really be the benefit that would bring him into the Medicaid Program and be able to provide his drugs through that program and also pay his deductibles and his coinsurance under Medicare.

I am hopeful that the legislature will see fit to implement that expansion. It will add about 30,000 elderly persons to the Medicaid rolls in this State, but I think it would be a tremendous benefit to those persons as we have heard illustrated in the story that Mr. Bennett told us this afternoon.

I am not going to read entirely the statement which I provided. I want to particularly target some comments dealing with surveillance, which I believe Mr. Morris mentioned.

We are very much in support of the points that Mr. Morris made of the need to have a better system in this country for assessing nutrition and hunger. I have listened to a lot of this through the years; that we have people on one side saying that people are starving everywhere and we will have denial on the other side that there is any hunger at all, and I think in my own humble judgment that, generally speaking, the answer is somewhere in between.

I wanted to cite for you just a figure or two on the trends in Federal funding for some of these programs in our State, and what we have been able to accomplish in terms of total funding for the same programs.

So, let me take maternal and child health. Starting back with the magic of the block grant—some people thought it was magic back in 1981—we, in 1983, received $7.5 million under the MCH block grant. That was our allocation for Mississippi.

In 1986, we received $6.9 million. That is a reduction of 7.9 percent. That does not, of course, recognize the further reduction due to inflation.

Mr. KOSTMAYER. What program is this for?

Dr. COBB. Maternal and child health block grant.

On the other hand, the total maternal and child health expenditures through our agency and out to all of our county health departments went from $12 to $18 million. We increased our maternal and child health effort 48 percent.

Mr. KOSTMAYER. You made up the difference.

Dr. COBB. We made up the difference through some earnings. We really did not get a lot of State money. We kind of scrounged. We have a lot of earnings programs, such as home health. We are a major provider. We are able to recoup some fixed costs, and we accumulated some funds which we were, during those hard years, able to plow back into these programs. We did receive some increases in State funds and local funds through those years, but I do not think it amounted to anything like 48 percent, a much smaller percentage than that.

The WIC grant went from $27 million in 1983 to $33 million in 1986 or about a 23-percent increase. We, on the other hand, actually increased WIC expenditures in this State about 40 percent and, there again, we were accounting through our accounting system for all of our in-kind and other efforts that we have of local staff and State staff who are paid from other funds but actually spend some time in administering the WIC Program.

One final comment or two about block grants. One of the biggest advantages that we receive from block grants, of course, is our ability to integrate our services and better use our staff. Prior to block grants, when the Feds labelled every dollar that came down, we had staff who worked on family planning, we had staff who worked on maternity or we had staff who worked on immunizations or whatever the program, and, frankly, sometimes, I got the impression they felt like they were working for CDC or for Washington rather than for our department in Jackson.

Under block grants, we were able to integrate those personnel, let nurses do nurses' work, if it was MCH, if it was an immunization or whatever the service might be, and we were able to comingle these funds a little more and better utilize them. We also got the State to move away from 10 separate appropriations bills. The State had been appropriating our money in little blocks, too, and they put it all into one big pot, and we were better able to utilize the total resources.

I think those are the main advantages from block grants. Unfortunately, with the blocks came, if not cuts, no increases there for several years. So, that was the offsetting factor.

To answer your question dealing with family planning, we have very active family planning programs in this State. This State has traditionally had interest in this program in its health departments. Dr. Underwood was one of the first State health officers. He received the Laskar award sometime in the forties—I have that in my office—for his efforts in implementing family planning in this State.

We have very good legislation. It authorizes us to provide family planning services through all of our county health departments in the State. We provide services to about 100,000 individuals, about 30,000 of those are teen-agers, sexually active teen-agers. We are able to provide service to them without parental consent. We like to have family involvement. We encourage family involvement, but we are not so tied up with it, that we are not able to serve people.

Agnes Hinton has a statement she would like to make, and I would be glad to answer questions. Dr. Rausa is here, I am sure, to help and Dr. Brooks has some things she wants to say, and I do not want to take all of her time.

Thank you.

[The prepared statement of Dr. Cobb appears as the conclusion of the hearing, see p. 207.]

Chairman LELAND. Thank you, Dr. Cobb. Very good.

Ms. Hinton.

STATEMENT OF AGNES HINTON, NUTRITION SERVICES DIRECTOR, BUREAU OF HEALTH SERVICES, MISSISSIPPI DEPARTMENT OF HEALTH

Ms. HINTON. Thank you for the opportunity to present a statement to you today as I did 3 years ago in Greenwood.

Dr. Cobb has told you the progress that we as an agency and as a State have been able to make in the area of access to prenatal care and the reductions we have been able to make in infant mortality. But he has also pointed out that many problems remain and I think that is quite evident.

As I look back, as Congressman Espy did, back over the testimony of 1984, I was struck by the number of recommendations I made in 1984 as well as other witnesses that are yet to be implemented, many of which have even a greater need today.

The following are some of the key areas where I feel changes still need to be made.

In the area of food assistance programs, we need improvement to better meet the food and nutrition needs of our population. Specifically, I feel the Food Stamp Program should be increased by 25 percent, the benefit level, that outreach programs for the new poor should be required, and that each State should be encouraged to develop a nutrition education plan as Federal regulations now allow.

Also, I believe nutrition education efforts should be expanded for food stamps, including an increase in the EFNEP or Expanded Food and Nutrition Education Program.

I believe funding for the WIC Program has been increased, and should be increased. It has been, as you heard, but we need further increases. The 1986 report of the Council on Maternal, Infant and Fetal Nutrition, the Advisory Council for WIC, and the Commodity Supplemental Feeding Programs on which I serve, does include this latest recommendation, does include that WIC should be expanded as soon as possible to serve at least 50 percent of the potential population, and that each fiscal year, an additional 10 percent of eligibles be added until all are served.

We also encourage that all current nutrition education components in the program must be maintained.

In the area of the school lunch and breakfast programs, funding and eligibility guidelines must be raised to allow more participation in those programs. The reimbursement rates for school breakfasts must be increased, and the programs should be implemented in all schools with a large number of low-income children.

We have heard a lot about the problems of the elderly and I certainly echo that, and feel that elderly nutrition programs must be rapidly expanded to meet the tremendous needs existing among the low-income elderly.

Also, I feel dietary consultation should be required at least at the State level for these programs to ensure that food dollars and education opportunities are maximally utilized.

Second, we need continued involvement of private and voluntary agencies and churches. It has been very encouraging to see the growth of food banks, food pantries, and emergency feeding sites. The political activism of groups, such as Bread for the World, who have chosen increased funding for WIC as a top 1987 legislative priority is encouraging.

All of these private efforts must be continued and expanded where possible.

Third, we need a nutrition monitoring system for our population. I think Jesse very eloquently pointed out the need for this, and under-nutrition should become a reportable condition. Despite efforts by a broad coalition of over 70 public health, scientific, professional, voluntary, industry and advocate groups, as well as representatives of State and local governments, a nutrition monitoring bill has yet to be signed into law.

In late April, the National Nutrition Monitoring and Related Act of 1987 was introduced as Senate 1081 and H.R. 2151. I would like to strongly encourage the members of the committee to see that this legislation is passed.

Sufficient nutrition education must be available to enable our population to make informed, appropriate choices regarding their food intake. While hunger and malnutrition often are caused by a lack of access to an adequate food supply, ignorance of basic nutrition principles and vulnerability to nutrition quackery are also factors.

As mentioned, all Federal food assistance programs should have a nutrition education component. Additionally, sequential nutrition education should be included in K through 12 school curriculum materials and as mentioned, our State is working in this area.

Another need is for required nutrition education components of various professional training, particularly that of nurses, physicians, dentists and nurses and teachers. One university in Mississippi now requires that all graduates pass a basic 1-hour course in nutrition, and I see that as a very positive thing.

On-going in-service education programs in nutrition also must be available to keep abreast of current knowledge, especially for health professionals and teachers. Yet, I do believe we are making progress.

As we have mentioned, we have applied to the Centers for Disease Control for grant funds to begin both a severe pediatric under-

nutrition surveillance system and a pediatric nutrition surveillance system, grant dollars which I understand this committee helped secure.

Mr. Leland, we have not heard yet on that. We should before the end of September. We hope to. If we do not get it the first round, we will go for it again.

We are beginning a very exciting project in the Mississippi Delta in conjunction with the Cooperative Extension Service EFNEP and the Meals for Millions Freedom from Hunger Foundation, a private organization, entitled Partners in Improving Nutrition and Health.

I am submitting a more detailed description of this project for the record. Our specific focus area in this area will be Leflore County and Humphries County. Project goals are to bring about local self-help activities that yield sustained improvements in the diet and health of low-income residents and to establish models for self-help nutrition and health improvement which are suitable for replication in other areas, and we are hoping to achieve that goal over a 5-year period, realizing that there are serious problems that must be addressed.

In conclusion, I believe that a serious problem of inadequate access to food and in many cases hunger exists in our State, but it exists also in many other areas of our country. I speak as one who has worked as a local nutritionist in Baltimore, MD, for instance, and I know there is hunger and malnutrition there also.

This problem must be addressed through both immediate and long-range interventions which involve private efforts in addition to those of State and local governments. However, I believe that the Federal Government must assume primary responsibility for leadership and resource allocation to solve this national problem, and I do commend the committee's work in this area.

Thank you.

[The prepared statement of Ms. Hinton appears at the conclusion of the hearing, see p. 216.]

Chairman LELAND. Thank you very much, Ms. Hinton.

Sister Brooks.

STATEMENT OF SISTER ANNE BROOKS, D.O., PHYSICIAN, TUTWILER CLINIC

Sister BROOKS. I cannot thank the committee enough for coming to our area this morning and, in particular, for your sensitivity to the people whom you visited. You listened with more than your ears, you heard with your heart. I think that is very important.

The little map that I am handing out to you I prepared after you left this morning, thinking that it might clarify some of the information that you are going to be given. It has to do with infant mortality rates in the Delta.

One of the things that I wanted to bring to your attention is that there are some folks who could not feel free to invite you into their homes and to share with you. They were fearful, fearful that they might lose their homes and perhaps lose their children.

Another thing that I wanted to bring to your attention, and you notice I am skipping page after page so you can get going here, is

that you may not be allowed to share in a private agony of some of the people who spoke with you this morning.

One thing needs to be made clear. There are some wage-earners and some retired people in Mississippi who think that Government checks are an invitation to forget work and to make babies. As you well know, the system badly needs an overhaul and a major restructuring, but I would like to point out that there are many farmers in the Delta who also could not make ends meet if they did not receive Government subsidy checks. The difference is that many families on welfare have no possibility of a job.

The principal problem that I want to address is ignorance. Ignorance on the part of Uncle Sam. Uncle Sam thinks people have refrigerators and electricity, he thinks people have a car and gas, he thinks people can get to a store with competitive prices, he thinks there are enough Meals on Wheels and programs for congregate dining for the elders. Uncle Sam seems to think that people have toothpaste and tooth brushes and fluoride in their water and access to dental care.

A number of my patients have no teeth. They are unable to eat food other than something that is very soft, which sometimes contains no protein.

Uncle Sam seems to think that the temporary job income has to be reported and food stamps adjusted, and as you found out this morning, in some cases, when the job is finished and the food stamps are gone, there is no food for the next month.

There is also an ignorance on the part of Uncle Sam that thinks because there are food programs, both Federal and private, there is no hunger. I think you know different.

There is also ignorance on the part of people who cannot read or do math well enough to compare prices. People who have not learned how to budget and who do not understand what tastes best is not always nutritionally best, and there are people who do not know what protein is.

I think I mentioned in my written report of one woman who came in 19 years old, who actually was quite huge. She weighed about 200 and something, I forget at this point how much. When I had her sit down with my nurse, who does our diet counseling, she came to me totally incredulous. This young lady consumed the equivalent of 20 breads a day, her one source of protein was one piece of bologna. She had no idea that there was any other way to eat.

Such ignorance can mean death, and I see it. Death not from starvation, but from malnutrition, death from diabetes, death from high blood pressure, death from stroke.

My written report is kind of a downer, and I apologize, because there are some good things going on. As you have heard already, Clarksdale has a program of workfare. I talked to the mayor, who is a personal friend, who says he only wishes he had $10,000 in discretionary funds so that he could pay the people who are saying, "Mr. Mayo, can we not work overtime?"—those who have obtained the jobs.

In Tutwiler, we are trying to establish a food bank. It is an ecumenical group that has gotten together. I do not know if you noticed the old, falling-down steak house on the highway, which is

where we hope to put it. We are having trouble raising the money because the food that we are going to buy from the food bank in Jackson is going to cost us 10 cents a pound. We also have to come down to Greenville as a distribution center, which is a far piece for us, but we are hoping somewhere to get the money to start this.

We are also looking at ways to address the infant mortality. I am very ashamed of Tallahatchee County—had 11 deaths in 1986 out of 293 children, and that is an infant mortality rate of 37.5. That is a disaster.

But Tallahatchee County also went from 66th to 81st out of 82 counties economically in Mississippi. Information from the Mississippi Data and Resource Center tells me that there is a 17-percent loss of employment in our county, and while I am talking about unemployment, you know, those unemployment statistics do not say anything because they never count the people who never had a job, and there is a whole work force out there that never was employed, so they never get counted. So, it is very distorted when you talk about unemployment is only 11 percent. That is wrong.

Only 37 percent of the people in our county have finished high school and we are looking at people who are 25 years or older, and there are lots of people who want to work, and, so, there it is.

We have got to have dental care. We have got to have access to it. Access means transportation and payment to the poor dentist. We have got to have food stamps closer to people and I think that is being clarified.

We have got to have help with the outrageous medicine expenses. I have patients who have diabetes, heart disease, heart arrhythmias, high blood pressure, who also have skin diseases and other associated things. Their medicine bills are $150 to $200 a month. I do not know if that classifies as, what will I say, catastrophic illness, but it is certainly a catastrophic bill because they will come to me and they will say, "I could not get my medicine, I had to buy food," and what can I say? Watch them drop dead because their heart does not beat right.

We have got to get sex education in schools, and I am a strong advocate, kindergarten or below. Teen moms have got to have access to prenatal care. We have a health department 5 miles south of us. I have said to girls, "You have to go down for the prenatal clinic, they do real good care there." And they do, but the nurse will say, "Well, you cannot come for 3 or 4 weeks, we are seeing 70 girls in a day." How can you give good prenatal care if you are seeing 70 girls in 1 day?

Teen-age pregnancy has got to be followed up in the home during the first week after birth. This is a program we are trying to start with the Mississippi Regional Medical Center in Clarksdale, to let me have the names of those from our county who deliver so that we can personally go to the home and prevent disasters, like nondiluted formulas that caused an infant death in my practice.

There is also a very big stigma attached to pregnant girls who try to go back to school or even who go to school while they are showing their pregnancy. That has got to stop, and I do not know how we are going to do that, except through education.

So, this is my challenge. You cared enough to come. I want you to take the small voices, take them back to Washington, and line

them up with the homeless and the hungry in Washington, and I want you to magnify those voices and fears and the ignorance of those who live in destitution and I want you to give us some action, so there can truly be liberty and justice for all.

Thank you.

[The prepared statement of Sister Brooks appears at the conclusion of the hearing, see p. 229.]

Chairman LELAND. Thank you, Sister, very much, for a very effective testimony.

Let me now turn to questions. Dr. Cobb, at the present time, we lack a systematic means by which to monitor hunger as has been indicated earlier. How would you go about devising such a system?

Dr. COBB. Well, I think I will turn to Agnes Hinton. She is our specialist, but I think we can incorporate our understanding of how to do community surveys and how to evaluate. Back a number of years ago, we had what was called a national health survey in this country, which I think when it operated gave us some very good indicators as to the health conditions of our people.

I think the methodology is available to us in terms of our knowledge about interview techniques, statistics, and all of that. I think it just takes a dedicated effort and a willingness to fund the surveillance system.

Now, Agnes, if you will help me with this, since that is what I would do at home, I will ask Agnes to advise me about how to structure it.

Chairman LELAND. Very good.

Ms. HINTON. Of course, there are a variety of things that can be done, depending on what you want. OK. I think I heard something mentioned before just about the food bank. Certainly Mr. Morris has very good records about who he is serving and that type of thing, but as far as knowing where our needs are out there and where our gaps in service are, I do not even think we have a clear picture of that. I think that is one of the things he was calling for, and I know we are not alone in that in the State.

So, even just a need for—I know some things such as have been done in your own States, just questionnaires that have been done in food stamp offices, through the WIC Program, you know. There are simple things like that can be done.

Now, if you want something that is more scientifically valid, then you go into a surveillance-type situation. One of the things that I think needs to be done is that there needs to be some type of mandated evaluation system in each Federal program, such as in WIC.

We spend millions of dollars on evaluations of WIC that then we have to fight with USDA, frankly, to make public because it turns out that WIC is doing a good job, when we do not even have any evaluation system built in, and I am speaking of something that is as simple as the CDC pediatric and prenatal nutrition surveillance, which I feel should be mandated as a part of the WIC Program.

It is very simple to collect that information. CDC does all the analysis. We have—I think we have 27 States now in the pediatric—no; 37. I am sorry. But there are only about 15 on prenatal.

So, you know, there are things like that that could be done for populations that are already being served, but it does not answer

the larger question of what about the people who are not being served by anybody. For that, we will have to go to a system such as was proposed for the pediatric population through CDC, the grant application we made for the establishment of the severe pediatric undernutrition surveillance system.

That, we looked at through five different populations. One, through the WIC population, the CDC surveillance population, picking up those children through that program that are very under-weight, very anemic, through that system, going through a reporting system of doctors and hospitals, making undernutrition reportable through that system.

We were intending to go through birth certificate follow-up systems, such as we are already doing now, to make sure our highrisk infants are in a system of care to try and be sure that, in addition, to collect some medical information on these children.

So, there are things like that that can be done, but it takes money to do it.

Chairman LELAND. Very good. Let me—while you have got the microphone, let me ask anybody to respond who wishes to, recently, the select committee conducted a hearing on strategies to reduce infant mortality.

At that time, we were informed by representatives of the Department of Health and Human Services that they discouraged the establishment of WIC Programs where health care is not accessible.

Mississippi is largely rural and access to health care is limited. What are your views on this policy and does it restrict the availability of WIC services?

Ms. HINTON. Well, first, let me say that our WIC Program is offered through the county health department in every one of our 82 counties. We also offer it through independent health centers. Eleven independent health centers provide WIC services.

So, our WIC Program is associated only with health care programs. OK. So, in Mississippi, that would not be a barrier. I do think it is the ideal way to go because WIC should be integrated into on-going health services. So, if the health care delivery system is there, that is the ideal way to go, and that is the way we have done it.

Now, whether or not if the health care delivery system is not there, you should prevent people from even getting the WIC help, that is another question.

Chairman LELAND. Very good. Dr. Cobb, how does the State health care system rely on the National Health Service Corps of Physicians to assure the availability of health care to low-income Mississippians?

Dr. COBB. I did not know you were going to ask that specific question.

We do under contract assist the department and the Federal agency with the administration of the program. If my recall is correct, we have something over 100 physicians who are serving in the State. I think Dr. Brooks would probably know the numberr better than I would.

I think it has helped some. My own impression is, and back several years ago I looked at this pretty closely as I served on a national advisory panel on that program, the problem has been that

there is a tendency for physicians not to stay. I think that just goes to the difficulty of keeping physicians in these areas. They are not, as we all know, the kind of areas that many people would like to live, particularly spouses and others who would like to have social activities, and it is very difficult now to keep even those we have in our State.

We have an increasing supply of physicians. We are up to about 3,000 practicing physicians in our State. I think that is putting us pretty close to what is supposed to be the minimum number that we need for population, but we have a distribution problem. We still have badly under-served areas. We have 30 or 40 counties, as I recall, that are listed under the core program as being underserved.

So, we have the numbers, but the people are not, of course, many times, in the right places. On the other hand, I do not think it is going to be feasible to have a doctor in every little crossroads in the future, as you were discussing earlier, because of the economic issues.

How can you expect to keep a doctor in Tutwiler when you lose Dr. Brooks, when she is no longer able and willing to serve as the missionary, so to speak? I doubt you can.

I think we are going to have to look at systems where we provide better transportation and better ways for people to reach the services in the county seat towns and the larger places, where we really, hopefully, can maintain services, and I think that is a reasonable expectation.

Chairman LELAND. Ms. Hinton, how would you compare the hunger problem existing in Mississippi today with the problems existing in the State 3 years ago?

By the way, thank you for your testimony then and now.

Ms. HINTON. The problem is, unfortunately, we have very little more information today than we did 3 years ago. So, 3 years ago, what we said was our impression from anecdotal reports, from the little bit of data we do have, from our employees reports of what they do, the families they see in their health care interactions, from service providers, that there is a problem.

I guess what I have overheard over the last several years is just more of the same and probably it has reached a greater intensity, but it is difficult to put any numeric factor on that just because we have no surveillance system.

Certainly, as Jesse said, he is doing a lot more toward giving out a lot more food, but that does not necessarily mean that there is more hunger today, it just means we are doing a little more about it.

So, it is hard to answer that.

Chairman LELAND. How extensive is the use of nutrition education services through the Expanded Food and Nutrition Education Program?

Ms. HINTON. Of course, EFNEP is through Cooperative Extension Service. We do not have it in every county in our State. I think the last figure I saw, I think there are about 25, and we have 82 counties. So, you see, there is less than one-third of the State covered by EFNEP.

Where we do have that, we do work very closely with them. In fact, I mentioned the cooperative project with Meals for Millions, the EFNEP will actually be the lead agency in Leflore County. We will be the lead agency in Humphries, working very closely with them.

So, we work as closely as possible where we have it, but we do have it in less, I believe, less than one-third of the state.

Chairman LELAND. What are your expectations about the Meals for Millions helping pregnant women?

Ms. HINTON. Certain pregnant ladies who are in a high-risk population, we will be looking at them, but we are looking broader and specifically in Leflore County, we are looking at the high-risk maternity patients. In Humphries County, we are looking broader at the general population.

What I am hoping is that we will be able to reduce infant mortality, that we will be able to reduce poor health outcomes, both by reducing low birth weight, by reducing the instance of anemia, by increasing weight gains during pregnancy. Those are some of the hopeful expectations of the project.

What we will be doing is having the EFNEP aides doing selective teaching in the home of our high-risk maternity patients with feedback to the health department.

Chairman LELAND. Dr. Brooks, how frequently do you see your clients skipping meals when food is scarce to make sure that their children eat?

Sister BROOKS. Very frequently. I have many patients who eat once a day. Sometimes teen moms eat twice a day and they feed their babies twice a day, which is something we try to be very vigilant about.

I cannot give you exact numbers, but it is very frequent.

Chairman LELAND. It is often assumed in this country that when a person fails to eat properly, it is because he or she lacks nutrition education and does not make wise food choices.

Based on your practical experience, how often is it that your patients are under-nourished because they cannot afford to buy food?

Sister BROOKS. I think——

Chairman LELAND. Realizing that the other is a problem, too.

Sister BROOKS. Yes. The other is definitely a problem. Sometimes it is a toss-up between food and transportation. Sometimes it is a toss-up between food and medicine. Sometimes it is a toss-up between food and rent or food and a Christmas present. It is hard to quantify.

Chairman LELAND. The majority of your patients are poor. What type of information programs or referral systems are available to help them gain access to Federal food and general assistance programs?

Sister BROOKS. Whenever we become aware of someone who is not on a program that they should be eligible for, we do our best to get them there. In many cases, it is a transportation problem, not necessarily an ignorance problem. They know the program exists; they just cannot get there. Like the food stamp situation.

In other cases, they are not eligible. Their income is maybe $5 too much or something like that. So, we just have to fold our hands and say sorry.

Chairman LELAND. Thank you.

The gentleman from Pennsylvania.

Mr. KOSTMAYER. Just briefly, Dr. Brooks.

We have heard so much about the causes of the problems here, a lack of an adequate diet, no job, no family planning services.

Is the most basic and fundamental answer to the problem that the Federal Government should be providing more money to all of these programs? Is that the bottom line or is there something else? There does not seem to be a simple answer.

Sister BROOKS. There is not.

Mr. KOSTMAYER. It seems as if there ought to be a simple answer because there are people who do not have enough to eat and it seems the answer is, well, simply provide enough food for them, but for some reason, it does not seem that simple anymore.

What is the answer? What should we do?

Sister BROOKS. Wow. Here I am on the hot seat.

I think, No. 1, we have got to take into consideration that Mississippi has finally passed an education act, so now we have a chance through the schools to get at everybody eventually. It is true that kids only have to go up to age 10, but now it is going to increase every 2 years now, instead of every 1 year. So, we do have a chance to start education.

The problem is not going to be solved in a hurry. It is not a band-aid. It is a structural problem that needs to be addressed and the structure needs to be remade.

Mr. KOSTMAYER. Is the schooling more important than what happens at home or is what happens at home more important than what happens in school?

Sister BROOKS. Sometimes the parents learn from the kids. One woman, a 38 year old who has very bad heart disease, lives in a cabin in the middle of no where. We went to visit her one day before Thanksgiving to bring her a Thanksgiving basket. She had three kids. They were all sitting on the bed with their backs against the wall, legs stretched out in front of them, doing their homework on the day before Thanksgiving. They had one light bulb hanging from the ceiling and she was determined that those children were going to learn. She could not read a word. She was determined they were going to learn and so she stood there while they did their homework on the day before Thanksgiving.

I do not know who learns from whom, but I think there need to be programs for adults as well, people who did not go to school or did not finish their GED, who just need to learn good nutrition, learn how to bring up their kids, learn how to take a temperature.

Mr. KOSTMAYER. Is money part of the problem?

Sister BROOKS. Yes. Money for transportation, money for teachers, money for materials, for videos.

Mr. KOSTMAYER. The Federal Government is not spending enough money on these programs in this State, is that right or is that too simple?

Sister BROOKS. It is too simple, but, yes, money would help. Money always helps when you have got a program that you want to start. You have got to pay people to do it. The only reason I am getting a social worker is because some rich lady in New York City is guaranteeing me a salary for 3 years. I do not know what hap-

pens at the end of 3 years, but for 3 years, I have got a social worker.

Mr. KOSTMAYER. Well, God bless those rich people in New York City——

Sister BROOKS. You bet.

Mr. KOSTMAYER [continuing]. Or several of us would not be here.

Well, I appreciate your testimony. Just let me say one other thing and you have received so many plaudits, I know you do not need anymore, do not want anymore, but I think one of the nice features about your attitude is you do not seem to be angry, and I think that is important, and we hear a lot of angry people, and I think the anger is very often justified. But you do not seem to have been filled with that anger yet, you seem to have directed it in a more positive way. I think that is important.

I hope it lasts. I do not know whether it will, but I hope it does. Thank you.

Thank you, Mr. Chairman.

Chairman LELAND. Any other comments or questions of our colleagues?

Mr. PENNY. Mr. Chairman, I do not have any questions, but I want to follow-up on just one or two points.

You were urging us to forget about this monitoring and record-keeping, and I would venture to say that the members of this committee are eager cosponsors of that bill or at least part of that bill and are trying to get that legislation passed.

OK. I did think of one question. I know we have got to move along here, but it has to do with food stamps, and whether identifying what you can use them for might tie into this nutrition issue, and I think we are more capable of handling that now than we used to be.

Not every store has got sophisticated computers at check-outs, but a lot of them do, and you can plug in a program that identifies the items that food stamps will pay for and items that it will not. Just a better way of making sure that the money that is given is used for those nutritional items that we know the family needs.

I was curious about your thoughts on that, if that might tie into the whole theme you are trying to develop here, better education and better nutrition and all the rest.

Ms. HINTON. I might just say we do have some of those in Jackson, but I do not think they have them in Tutwiler.

Mr. KOSTMAYER. Well, I am aware of that.

Sister BROOKS. I am all in favor of that program. The whole idea of not only education and training, but also backing up—of not only educating the person but backing up the education with reinforcement.

It is one thing to walk in and buy a bag of potato chips. It is another thing to walk in and take a bag of potato chips off the shelf and go to the cashier and have it go beep.

Chairman LELAND. Any other questions?

Dr. COBB. Mr. Chairman, may I respond to something?

Chairman LELAND. Dr. Cobb.

Dr. COBB. I would like to make a comment here in reference to the direct distribution system for WIC. I think that one of the advantages of direct distribution is that we provide the nutrition edu-

cation with the very foods that are needed and where the skilled professional can assure that we are making those foods available and that the individual takes those particular foods home, and I think we have a lot of opportunity for education.

Although I am not saying that we have fully realized that opportunity as far as the educational potential.

Again, let me say that our reason for being in the direct distribution system was not some long thought-out plan on our part. I think we accidentally chose the direct distribution system because, as Agnes or someone has said, we have the clinic system with the community health centers and our health departments, and we have a pretty good clinical system in this State for maternal and child health. We felt that if we could just tie the direct distribution, when WIC came along, into the clinic system that maybe it would function then as a project, and as it grew, we did.

At one point in time, we tried the vouchers. We did a pilot in three counties, and as I recall, the results showed that the recipients did not like it as well as the direct distribution system. It was also much more expensive. Obviously, keeping up with all the documents required a very highly sophisticated computer technology, although we are getting into that now with direct distribution, too.

Now, there are some disadvantages in that you cannot supply as much in the way of perishable items such as fresh milk, but we use the highly pasteurized milk that has a long shelf life. We do get fluid milk. It does not taste quite like the other milk, but it is pretty good. I have drunk some of it, and it is pretty good.

We cannot supply, I do not think, fresh eggs in many of the counties. That is a disadvantage. There are certain disadvantages, and I want to point that out, and the final thing I wanted to say was that I do not advocate it as the ideal system for every jurisdiction by any means. It would not work in many areas of our country, but it does work in Mississippi, and I suspect it would work well in some other southern States, but once you get into one system, it is very difficult to go to the other system.

Chairman LELAND. We are going to have to leave, but I understand that we are having some problems with our flights. The airline representatives are saying that if we do not travel from Greenville to Memphis, they are going to cancel our reservations in Memphis, which means—I know that this is not necessarily the proper committee to deal with it, but I think we are going to have to look seriously at re-regulating the airlines.

Let me thank all of you. On a final note, 40,000 people a day die of starvation, malnutrition, and hunger in the world. That is about 28 people a minute. Twenty-one of those 28 people are children. That is the travesty, the tragedy of our times. If there was an earthquake tomorrow in any country of the world, all of the American people would clamor to do what they could to help if there were 40,000 people who were dead, who died tomorrow. That is the kind of drama that we are going to have to express about hunger in the world because every day it happens.

We hope to be attentive. Certainly, the people of the Mississippi Delta have been very hospitable to us. You have given us great information to take back to Washington.

We have heard those little voices. We are going to do what we can to enhance and to reverberate those voices to do what we can to help the people, not only of the Delta, but the State of Mississippi.

We want to thank the staff of Mike Espy for what it has done to support our efforts here. They have been industrious and most efficient. We appreciate them.

Let me thank also Dr. Shirley for his expertise. He is accompanying us this time. He has come a long way to be with us and has stayed with us throughout, and he was with us in 1984 also. We love you and appreciate what you have done.

Mike, your people are beautiful. They are wonderful. They deserve the attention of the Congress of the United States. This is just not enough attention to be paid. We will make sure that the people in the Congress, our colleagues in the Congress understand their plight.

Thank you so much.

This committee hearing is over.

[Whereupon, at 4:50 p.m., the hearing adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. MIKE ESPY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

MR. CHAIRMAN, I would like to welcome The Select Committee on Hunger to Mississippi Valley State University and the 2nd Congressional District of Mississippi. The citizens of the state and I thank you for the opportunity to share rural concerns relative to an issue that plagues our nation...hunger. Additionally, I want to express my appreciation to the witnesses that will appear before the committee today and to those persons in the audience...both of whom have interrupted their schedules to be with us and delayed personal matters in an effort to share the various aspects of public assistance programs here in the state.

In 1984, The Select Committee traveled here to Leflore County to gather information on how well our residents were being served by anti-hunger programs such as food stamps and WIC. Today, three years later, significant gains have been realized in areas such as infant mortality rates and Medicaid eligibility requirements. Infant mortality rates have decreased from 14.4 in 1984 to a current rate of 12.3 per 1,000 births as a result of active campaigns of educational based programs aimed at preventing unplanned pregnancies, comprehensive and frequent prenatal care and accessible perinatal and preventative health services. Mississippi is among the states that has elected to implement the new Medicaid eligibility requirements allowed under the 1986 Omnibus Budget Reconciliation Act. Effective October, 1987, Mississippi will raise its needs standard for pregnant women and for children under one year of age, thereby extending medical coverage to a projected number of over 12,000 women and children in 1987.

Although we have made gains, we cannot be content. Hunger

still exist at a level which requires our continued support of food assistance programs.

Hunger, health related problems, housing and education are directly proportionate to employment. National statistics for the month of June show unemployment rates at 6.3%, the State of Mississippi with 9.8% and the 2nd Congressional District with a disturbing average unemployment rate of 13.8%. We must bring jobs into our area. If I may Mr. Chairman, I would like to give a brief overview of the county where we are now seated, Leflore. The average quarterly unemployment rate is 11.25%; 27% of the county's population is below poverty level; of 13,003 total housing units, 6,738 are rental units; 50% of the county's population has not received a high school diploma; 21% of households are headed by a single parent. While these figures reflect the situation in Leflore County, they are again representative of my district as a whole.

Statutory changes in many public assistance programs have occurred since the committee last visited in 1984. Again, our purpose is to gather information on how those policies have impacted the local communities and the families they were designed to assist.

In closing Mr. Chairman, I would like to reflect on a promise made during my campaign. That promise was to be the best Congressman this district has ever had. I sought and received committee assignments that directly affect this district and the problems facing its constituents. I have seen and heard firsthand of the experiences of hunger, declining family farms and stories of inadequate resources. Through my election to Congress and my appointment to The Select Committee on Hunger, it is my endeavor to bring focus to hunger and other problems here in our state and district. Thank you Mr. Chairman.

Prepared Statement of Hon. Mickey Leland, a Representative in Congress From the State of Texas

Good morning. I am Congressman Mickey Leland, Chairman of the House Select Committe on Hunger. I would like to thank Congressman Espy for inviting the Select Committee back to Mississippi to reassess the impact of Federal assistance programs in alleviating the hardships of hunger and poverty among low-income Mississippians.

In 1984, the Select Committee visited Greenwood to examine the accessibility of Federal food and income security services to low-income residents of this State and the effectiveness of these programs in helping participants achieve a higher quality of life. In Mississippi we found the highest infant mortality rate in the nation; a vast number of poor people failing to receive benefits to which they were entitled; and, families who were forced to choose between having a decent diet and having a roof over their heads.

Since that visit, a number of changes have occurred. The State has approved programs to aid those living in poverty and Federal legislation revising the Food Stamp, Aid to Families with Dependent Children (AFDC) and a host of other major assistance programs have been enacted. The Select Committee is here today to see what impact these policy and programmatic changes have had on the lifestyles of the poor and what additional actions we must take to improve their quality of life.

We have a number of distinguished witnesses who will discuss the achievements that have been made in Mississippi and provide us with some guidance as to what additional battles must be waged to vanquish hunger and poverty in the Delta.

Thank you.

PREPARED STATEMENT OF JIMMY S. BARNES, MISSISSIPPI VALLEY STATE UNIVERSITY

To: Chairman Mickey Leland of the Great State Of Texas

Members of the United States House of Representative
Select Committee on Hunger

Congressman Mike Espy, Select Committee and Representing
the Proud and Beautiful People of the 2nd Congressional
District of Mississippi

To the Community leaders who toil in the vineyards of
Community Service every day.

Ms. Joey Kraimer of Greenwood who worked relentlessly in
every effort to relieve human suffering.

Members of ROC Holmes County who have been part of the
front line in the battle against poverty and injustice

Ladies and Gentlemen:

I bring you greetings from our President, Dr. Joe L.Boyer, who has asked me to express his regrets for his absence due to prior committments to the annual convention of the MVSU National Alumni Association.

From the Administration, Faculty, Staff and Students of Mississippi Valley State University

For those of you visiting us for the first time, we hope that some day in the future you will return to share ideas, dreams and hopes with us.

For those of you who have visited us before, welcome back. For we too are concerned about the problems that face this nation and the many communities in this state.

Dr. Boyer recently recommitted MVSU to the cause of human services when, in 1984, he met with members of the university and authorized the establishment of a Center For Community Development, a Center for Economic Development. We know that in spite of meager resources we need to extend our hand and our arm to the community we serve. Now, MVSU has an Economic Development Center -- Funded to develop programs related to small farms, small businesses, young entrepreneurs and many others. This program is headed by Dr. Robert Young.

The Center for Community Development has encouraged the Development of Programs that focus on the elderly, teen pregnancy prevention, teen mothers support programs, substance abuse prevention. In addition we have in place the Juvenile Opportunity Bureau-a Community-Based Alternative to Incarceration of Serious Juvenile Offenders in Sunflower County, Mississippi. This program is directed by Mr. Robert Moore, of the Social Work Program. This program is funded by the Governor's Office of Criminal Justice Planning Commission.

Mr. Chariman, we welcome you here because the destiny of Mississipi Valley State University is inextricably entwined with this district.

We welcome you because we know that when it comes to the important matters that you will discuss here today, the isles become narrow and they must.

Because the Politics is a poor desert for a meal that a child or elderly missed. Again, on behalf of this university and the Community we serve, welcome. We hope that the insights you gain here and on your tour of this district enable you to continue to provide the requisite resources, Along with the guidelines and standards for the many services the people of this district and this great nation need and deserve.

WELCOME!!!

Prepared Statement of W.B. Chism, Director, Department of Human Development, Office of the Governor

Mr. Chairman, Congressman Espy, and other distinguished Committee members, I bid you welcome on behalf of Governor Bill Allain and Mr. Roy Thigpen, Executive Director of Federal-State Programs. They asked me to convey their disappointment at being unable to attend the Select Committee on Hunger's hearing here at Mississippi Valley State University. In this brief appearance before your Committee I should like to confine my remarks to four points. I hope to provide an environmental overview, an introduction of certain initiatives, an outline of some short term goals, and finally, an appeal for your continued assistance in our struggle against poverty.

We appreciate the opportunity to share with you our impressions of the efficacy of federal antipoverty programs. If there is indeed a continuing "war on poverty," Mississippi has been in the trenches for two decades. We have come a long way (having had further to go) and have an equally difficult journey remaining. I would be remiss to imply that inadequacies in federal programs account for all the shortcomings in Mississippi's antipoverty campaign.

Background

Our executive branch of state government, with semi-autonomous social service agencies, discourages a comprehensive human development strategy. Even with the current unprecedented level of cooperation from our Health, Welfare and Mental Health Departments, the Governor's Office is frustrated by a structure which encourages the allegiance of these agencies to independent boards. There is a move afoot to rectify this situation by constitutional change. This will eventually lead to better coordination of federal and state efforts.

Mississippi's own financial contribution to these programs is less than average, keeping benefit levels down. Our inability to secure adequate tax revenues stems from our reliance on agriculture, fossil fuels, and low and semi-skilled manufacturing as the major sources of income. Mississippi is at the mercy of world commodity prices and

currency fluctuations, and has suffered revenue shortfalls in recent years. Our personal income tax base is limited to a relatively small percentage of adults, given our widespread poverty. Yet one should note that our average tax burden is comparable to regional figures, and somewhat greater when "ability to pay" is calculated.

One major reason for our dearth of tax dollars is the legacy of neglect toward a large segment of our population. Until very recently, Mississippi did not invest enough in the education, training and health services of the poor, rural, largely black work force. The resulting substandard skills level and immobility in the job market have limited our efforts to diversify into more profitable enterprises.

Fortunately, Mississippi's social, political and economic thinking has changed; I dare say more than any other area in the country. We realize that human capital is the most important element in the move to prosperity, and have begun redirecting our resources accordingly. In a moment, I shall provide illustrations of this new approach. But first, I must mention certain side effects of the antipoverty programs in Mississippi's unique social and economic environment. In the aftermath of the Great Society, despite all the good intentions, we are left with a swollen underclass of second, third and soon to be, fourth generation welfare families. Few of these people have ever witnessed the "American Dream" of rising to success from the depths of poverty. The programs' emphasis on subsistence rather than self-sufficiency discourages personal initiative. The cumbersome regulations from the multitude of federal and state agencies providing these services confuse even the most energetic. We have inadvertantly promoted dependency.

Mississippi's Initiatives

The Governor's Office realizes that we must address the "long term dependent" in a novel way if we are to break this vicious cycle. A central theme has been

interagency cooperation in service delivery. We realize that funds are limited and a maze of service delivery is counter productive.

Our Social Service Block Grant Negotiated Investment Strategy (NIS) is one way of reducing duplication of effort while ensuring a prioritizing of services. In 1985, the Governor's Office of Federal-State Programs, in conjunction with the state Departments of Health, Mental Health, Welfare, Council on Aging, and representatives from the Health and Human Services block grant advisory board first negotiated a strategy for administering the $20+ million Social Services Block Grant. They developed guiding principles, definition of services and a procedure for allocating funds among the agencies according to predetermined priorities. Administrative costs were reduced from over 15% to 1%, interagency turf battles subsided, and service delivery improved.

Since then, our emphasis on coordination has resulted in joint administration of Title III transportation funds (OAA) with Section 18, U.S. Department of Energy dollars. Now federal funds for the elderly are better utilized.

We recently completed a housing rehabilitation project in Northeast Mississippi using Farmers Home Administration grants, U.S. D.O.E. Weatherization dollars, Petroleum Violation Escrow funds and local government resources. The local Community Action agency, funded in part by the Community Services Block Grant, helped coordinate the project. We hope to expand this practice.

Our Office of Job Development and Training (JDT), using JPTA grants, is increasingly involved with the state-funded Project Second Chance, a program linking released offenders with volunteers in the communities to which they return. JDT has been instrumental in job training and referral, thus reducing the likelihood of a return to prison. PSC's present recividism rate of less than 5% will be even more impressive with greater interaction with JDT.

The Office of Energy and Community Services, the recipient of the state's Community Services Block Grant will soon begin exploring possible overlaps in service

delivery with the Job Development and Training office. Currently, employment training and counseling is one of the seven service categories offered by OECS in its $5.5 million grant. Given the size of our JTPA grant ($30 million) and the extensiveness of their training network, we may find CSBG funds are better utilized elsewhere.

In all these instances, our aim is to lower administrative costs, and reduce the red tape. We believe both the taxpayer and the service recipient better appreciate government efforts when we accomplish these objectives.

The Governor's Office has not limited its initiatives to improvements of interagency coordination. Realizing that our unique problems require innovative solutions, our Department of Community Development recently funded economic initiatives projects in two depressed Mississippi counties. DCD solicited from the ten most economically destitute counties, proposals for a comprehensive development package. Rather than dictate to local officials what was needed in job training, industrial infrastructure, housing, day care, etc., DCD encouraged the counties to draft their own development strategies. We plan to repeat the process this year, using self generated needs assessments to tailor the solutions to such acute poverty.

Another pilot project recently funded and directed by the Governor's Office was a school nurse program in east central Mississippi. In selected secondary schools, a nurse was present for extended health education and special counseling. The reductions in teen pregnancy rates and chemical substance abuse were phenomenal. In the process, many cases of child abuse and neglect were uncovered and remedied. The program met with such acclaim that the Legislature opted to fund the school nurses statewide.

Activities in the Near Future

Perhaps the Governor's Office's most ambitious pilot project is its welfare reform proposal, now in the final stages of planning. One of seven states in a

Corporation for Enterprise Development experiment, Mississippi hopes to explore self-employment initiatives as one alternative to welfare dependency. By identifying opportunities in the service economy of this state, and providing "incubator facilities" and limited technical assistance to fledgling businesses, this project would test the potential for this alternative to the welfare system. During the transition, the traditional disincentives to work (lack of child care, transportation difficulties, health care expenses) will be minimized using state funds. Portions of SSBG and JTPA grants are being utilized in this project.

As we implement these pilot projects we also direct our attention to productivity increases in other service deliveries. Competitive bidding practices for our elderly nutrition programs recently made possible an additional 130,000 meals through a 28¢ per meal reduction in cost. We are moving to unit cost contracts in all our aging programs, and hope to have the same practice in place in our Office of Energy and Community Services by late 1988. We have a timetable for upgrading our data processing capabilities so that we can provide subcontractors with information helpful in tailoring sevices to recipients. Throughout the Department of Human Development we are a under self-imposed pressure for productivity increases. We reason that a dollar saved in administration is a dollar more for services to the needy.

The Governor's Office of Federal-State Programs is scheduled for legislative reauthorization in 1988. During that time, policy makers will be searching for the best structure of service delivery. We are optimistic that they will use this opportunity to reorganize the overall structure of antipoverty programs in Mississippi.

Commensurate with this action is a plan for a long range Human Development agenda in this state. In expansion of the N.I.S. concept, agency officials, private sector representatives, and advocacy groups are now moving toward an extended plan of action.

Mr. Chairman, I respectfully suggest that Congress can assist us in doing a better job of helping the poor. Consolidation of similar transfer payment programs, such as food stamps and AFDC, would save us a lot of headaches. The concept is applicable to other federal programs, too. We have three sources of federal funds for housing improvements, each with different operating cycles and series of regulations (CDBG, Farmers Home, and DOE).

If you are unable to combine similar programs, then we ask that you allow more flexibility at the state level. For example, the 15% transfer limit of the LIHEAP grant to the Weatherization Program sends the wrong message to the service provider and the recipient. Instead of allowing more money for energy conversation of owner occupied low income housing, we set aside the bulk of the funds for one-time payments of energy bills. Our studies show the average weatherization costs are recovered in two season's utility bills savings. Congress should also compare the potential benefits from the purchase of weatherization supplies and the legitimate work created with the gains accruing to the utility stockholders under the present system.

Our third suggestion is that grant or program consolidation plans not be used as a guise for reduced funding. Similarly, the Petroleum Violation Escrow funds should not be considered as a replacement for U.S. DOE grants. Our energy services budget has been cut by half in three years, yet PVE funds awarded to "replace" them do not begin to make up the difference.

Finally, we ask that grant procedures be further modified to reward success. If Mississippi is creative in its use of federal monies, and results are impressive, we should be rewarded.

In closing, I wish to again express appreciation for the opportunity to share with you our perspective in the Governor's Office. We are excited about the new direction we're heading, and look forward to making significant strides in the near future.

JTPA

Considerations for the
Select Committee on Hunger

I. How Can We Improve the Legislation/Program?

1) Remove matching requirements.

States with very limited resources have a very difficult time in meeting current JTPA matching requirements. More wealthy states could simply match with cash and by-pass the administratively burdensome and costly task of determining in-kind match. Mississippi, unfortunately, at this time, does not have that option. JTPA was created to serve the economically disadvantaged. The State of Mississippi, if personified, would be economically disadvantaged.

2) Reclassify the cost of Employment Generating Services.

Currently, the JTPA regulations prohibit the classification of employment generating services as training costs. Employment generating services are needed to create job opportunities in depressed areas where training would be otherwise futile. Current cost limitations and categorization severely restrict the level of employment generating services which could be successfully administered.

3) Remove disincentives included in other legislation to encourage participation in JTPA.

Due to the limited educational capabilities and work history of ADC recipients in Mississippi, entry level jobs are often the first placement option. However, wages earned are not sufficient to cover housing, health care, child care, and other family essential needs. Therefore, amendments to other federal legislation is needed to phase-out assistance programs, i.e., ADC, food stamps, housing, and medicare over a period of adjustment. At the very least, ADC recipients should be assured of basic medical services while being "weaned" from pubic assistance and becoming self sufficient.

4) Build on the JTPA employment and training system.

Welfare reform is currently a major legislative consideration. Reform measures include the provision of employment and training services. Any enacted legislation should build on the JTPA system and preclude the establishment of alternate systems.

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5) Recognize rural, sparsely populated states.

The JTPA legislation ideally suits highly populated states with distinct labor markets known as urban bias. Although rural states are in the minority, difficulty is encountered in administering all JTPA requirements as envisioned by Congress and the Department of Labor. For example, five percent of Title II-A funds are for state administration. This is to finance the participant management information system, participant follow-up, monitoring, auditing, technical assistance, policy establishment, council expenses, etc. Such highly technical and detailed systems are expensive and extremely difficult for rural states to finance on the limited funds available.

6) Restructure performance standards.

All of Mississippi's Service Delivery Areas are meeting or exceeding their performance standards. However, despite this acceptance and support, it becomes apparent that program operators are encouraged to cater their services to some categories of individuals among the eligible population but not others. They are discouraged from serving individuals for whom a successful outcome may be basic skill competencies achievement rather than immediate employment. It is suggested that performance standards be revised to encourage slots to provide more longer-term and competency-based training for both youth and adults who need more basic skill development to become employable.

7) Increase funding for labor market information.

Funding specifically designated for LMI has been substantially reduced. States which have large JTPA 5% funds or increases in Wagner-Peyser allocations can easily supplement LMI resources to provide sufficient data. However, states with small JTPA funding and decreases in Wagner-Peyser allocations do not have the financial resources to insure adequate availability of LMI. Without adequate labor market information, planning for jobs in demand is hindered.

8) Provide JTPA funds to the state as a block grant.

JTPA funds are allocated by subpart. The disadvantage of this methodology is that programs and eligibility differ by title and subtitle causing varied reporting requirements by program as well as by participant type. With a block grant, states could tailor spending to meet local and special target group needs. Federal regulations and reporting requirements are reduced to the minimum necessary to assure that the broad purpose of the blocks are being observed, state programs comply with the law, and funds are spent for purposes intended by the law.

II. How does Mississippi's unemployment situation affect implementation of JTPA?

1) Availability of Jobs.

The JTPA system is performance driven and is judged primarily on the ability to train and place the economically disadvantaged in jobs. With one of the nation's highest unemployment rates, Mississippi simply does not have sufficient job openings in a great portion of the state to justify training. In fact, a major effort is devoted to retaining jobs. Without job creation efforts, job training is futile.

2) Rural nature of State.

Much of the high unemployment exists in the state's rural areas. Transportation and other support services such as child care are virtually nonexistent in these areas. Without these services, our target group is unable to take advantage of training available even within commuting distances.

3) Competition for Jobs.

Given the high unemployment rate employers have the market advantage. The more highly qualified in experience and education have a distinct advantage in competing for limited jobs. Those less fortunate are restricted to low wage jobs if any and the "job brokerage" or job development/placement function is more expensive on a per person basis.

The following two projects were funded under the FSP Economic Initiative (CDBG Demonstration):

1. Applicant: Holmes County

   Project Description: This project consists of:

   (a) a loan to establish a wholsale plant nursery creating 25 jobs;
   (b) the replacement of the roof on an industrial building owned by the City of Lexington retaining 70 existing jobs;
   (c) the establishment of a revolving loan fund to assist farmers in the production of non-traditional crops such as muscadines, blueberries, vegetables;
   (d) the renovation of the City of Lexington's wastewater treatment plant;
   (e) the relocation of water and sewer lines to allow the construction of a bypass between Highway 17 and Highway 12 east of the City of Lexington;
   (f) the renovation of a community facilities building in Durant which is used for food stamp distribution and senior citizen meal service;
   (g) the renovation of an abandoned school building in Tchula to accommodate a senior citizen services/crafts center which is being displaced from its present location;
   (h) the provision of child care services to an additional 25 children for two years (Children of workers employed by the assisted industries will be given priority).

   Funding:

CDBG:	$ 566,210
Other:	463,225
Total	$1,029,435

2. Applicant: Noxubee County/Brooksville
   (Joint Application)

   Project Description: This project consists of:

   (a) a loan to Prince Lumber Company to purchase new computerized equipment to create twenty new jobs through increased efficiency;
   (b) the construction of a Social Services Building in Macon to house the Welfare Department, Food Stamp distribution, and other activities;
   (c) the purchase and renovation of an existing building in Brooksville to house a senior citizens nutrition/ activities center, library, Food Stamp distribution, sheltered workshop for retarded/handicapped adults, and other activities.

   Funding:

CDBG:	$ 565,200
Other:	221,750
Total	$ 786,950

SCHOOL NURSE PROGRAM

Placing public health nurses in the schools to work directly with students has proven very cost-effective. In pilot projects in the Meridian and Greenville areas, public health nurses directed health education toward prevention of pregnancy and promotion of healthful and responsible lifestyles for adolescents. They provided health screening, nutrition education, child abuse/neglect detection, first aid, and counseling in the areas of drug and alcohol abuse and mental health. The nurses also referred students who needed other professional services.

One school nurse, who can provide care for 750 students, costs approximately $16,000 each year---just $22 per student. In the Meridian-area pilot project, teen pregnancies dropped from 56 in the year before the project to 12 in the first year. Based on Mississippi vital statistics and projected costs of care, one public health nurse in the school system can prevent future costs to the state of over $700,000.

Taken from statements by
Dr. Alton Cobb, State Health
Officer

ECONOMIC INDEPENDENCE THROUGH SELF-EMPLOYMENT

A
CONCEPT PAPER
ON
WELFARE REFORM

PREPARED BY
THE GOVERNOR'S OFFICE OF FEDERAL-STATE PROGRAMS
DEPARTMENT OF PLANNING AND POLICY

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Economic Independence Through Self-Employment

I. INTRODUCTION

The problem of poverty has plagued much of the potential that Mississippi may have to provide a good quality of life for her citizens. Social welfare policy designed to alleviate the problem has created one of the most complex systems of our society. We must begin to address the problems of our welfare system if we are to boost our national and state economic growth.

The overriding theme of most welfare reform approaches is that the welfare system must change from an income assistance program with a minor job component, to a job program with an income assistance component. Isabel V. Sawhill's article, "Anti-Poverty Strategies for the Next Decade", presented six principles upon which to base a welfare reform strategy:

- Work has value, quite apart from the income it provides. Our society expects most people to work and people feel better about themselves when they are working.

- Parents should support their children. Bringing a child into the world implies a commitment on the part of both parents to provide care and financial support for that child. Moreover, such a commitment may require delaying parenthood, limiting the size of one's family, or families, and sending more than one earner into the labor force. These have always been the routes to upward mobility among disadvantaged populations and are now also commonplace among the middle-class.

- Where people work and support their families but remain poor, they can expect to gain the sympathy and thus the support of the rest of us. This principle provides the basis for a new social contract between the taxpaying public and those needing assistance. Put most simply, it is a commitment to help those who help themselves.

- Even with a new social contract in effect and with a set of redesigned policies to go with it, there will still be many people who remain poor through no fault of their own. The historically high unemployment rates of recent years, the failure of the minimum wage and personal tax exemptions to keep pace with inflation, and serious trade dislocations have all swelled the poverty population for reasons that are entirely beyond people's control and, indeed, are outside the purview of social welfare policy as conventionally defined. These problems need to be addressed directly.

- Special efforts may be required to deal with one subgroup of the poor, the so-called underclass. In addition to the measures outlined above, breaking the cycle of poverty for this group necessitates learning more about the problem (currently ill-defined) and mounting a diversity of experimental efforts to move them into the mainstream.

- Even if all of the above steps were taken, and were reasonably effective, a substantial number of people would remain poor. An affluent society should be prepared to take care of such people in dignified ways.

In brief, Ms. Sawhill's article suggests that any new "War on Poverty" should have the following components: substituting work for welfare whenever possible; strengthening family responsibilities; improving job opportunities for those attempting to work their way out of poverty; mounting more intensive efforts to break the cycle of poverty for the small minority of the poor who appears to be locked into dysfunctional life styles; and providing income assistance to those who still remain in need.

An experiment now being developed by the Governor's Office of Federal-State Programs (FSP), Department of Planning and Policy (DPP), is a Self-Employment Initiative (SEI) for welfare recipients. It is an approach to welfare reform based on the

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assumption that welfare recipients want to work if given a decent job and wage.

This position paper outlines the theoretical framework and context in which we are designing a SEI. This paper covers the following issues: (1) The role of Corporation for Enterprise Development in designing and implementing a self-employment initiative; (2) the data usage and methodology for SEI; (3) comparison of other states' welfare reform initiatives; (4) social services support systems; (5) the impact of Medicaid requirements on the SEI; (6) JTPA's role in welfare reform; (7) an examination of the unique aspects of welfare recipients starting their own small business; and (8) the next steps in designing this project.

II. THE CORPORATION FOR ENTERPRISE DEVELOPMENT (CFED)

The SEI will be the first coordinated, systematic and multi-state effort to explore the potential for self-employment as an opportunity for welfare recipients to attain economic independence. The following sections will describe the services that CfED will perform for the Department of Planning and Policy. The CfED will coordinate and assist the State and its contractors to carry out their objectives in the first year of the four-year project. CfED will provide these services under a $50,000 one-year contract, which may be extended.

Program Design

CfED and its consultant team will assist the Department of Planning and Policy to prepare a detailed design for the state's self-employment pilot project. The design will include the following components:

- Objective of the pilot project
- Specifications of the necessary elements of a self-employment support system

- Criteria for selecting local support service deliverers
- Identification of regulatory waivers to be secured and design of wage pool or other relevant mechanisms
- Preparation of any necessary surveys of recipients
- Utilization of relevant resources from other programs and organizations
- Budget and funding plan
- Evaluation preparation and methodology
- Preparation of project workplan.

Program Implementation

Once the plan is completed and approved, CfED will assist in the implementation of the following:

- Helping to identify local program deliverers
- Brokering resources from other agencies (foundations, banks, etc.)
- Supplying technical assistance (directly and through expert consulting) for support service delivery and business support systems including access to credit and staff training, and assisting with the preparation of waiver applications to federal agencies.

Program Refinement/Interstate Interchange/Troubleshooting

- Arranging two (2) one and one-half day meetings with other participating states and leaders in the field which will be hosted by a participating state
- Establishment of a computer network for ongoing interstate communication (if desired)

- Provision of expert assistance and consultation on program operation and curriculum by CfED, Manpower Demonstration Research Corporation (MDRC) staff and relevant experts through regular visits to the program site, and by telephone and written communications.

Evaluation

- Provision of data input forms; establishment of procedures; and site monitoring

- Preparation of interim evaluation at end of year.

Federal Liaison and General Publicity

- Negotiations with the Office of Family Assistance and the Health Care Financing Administration of the U.S. Department of Health and Human Services and the Department of Agriculture's Food and Nutrition Service for regulatory waivers as needed

- Providing information and materials on the overall demonstration project to relevant audiences and the general public.

Background Materials

- Free access to a wide range of relevant CfED studies and manuals on transfer payment investment, entrepreneurship, self-employment and economic development

- Ten (10) complimentary subscriptions to The Entrepreneurial Economy, CfED's review of effective enterprise develoment strategies (ten issues per year).

III. RESEARCH METHODOLOGY

Fifteen sample counties were selected to develop trends and make projections (See Attachment A). Extensive data collection on all eighty-two counties would be very time consuming and a

possible waste of efforts. The fifteen sample counties were divided into three levels based on degree of economic distress. There are several socioeconomic variables that will be used to conduct a comparative analysis (See Attachment A). This will help determine such factors as site selection, educational level of participants, the potential pool of welfare recipients, as well as designing the request for proposals (RFP). The discussions to follow are based on the consideration of data in Attachment A.

IV. OTHER STATES' WELFARE REFORM INITIATIVES

We have identified a number of similarities and differences in other states' welfare reform initiatives. Mississippi has several unique characteristics and recommendations will be offered for dealing with them.

Mississippi is on the right track in trying to identify early socioeconomic traits of our welfare recipients and the potential for various employment projects. Massachusetts' Employment and Training (ET) Project is praised by CfED for its careful assessment of recipients' abilities and needs at the program implementation stage. Mississippi's plan will also include this step, yet we must take greater care than other states to use our recipient profiles and economic data to plan our program. Success comparable to Massachusetts will be more difficult to achieve here because of our depressed economy, and the typical recipient in Mississippi is "harder to employ" than in Massachusetts. The needs assessment will help tailor our program design, which may be different from other states.

Any welfare reform plan for Mississippi will include at least four agencies involved in social service delivery. Three of these are not directly responsible to the governor. No other state attempting welfare reform has the same governmental structure. The United States General Accounting Office (GAO) report cites the various federal funding sources for welfare initiatives as exacerbating administrative complication [Job Training and

Partnership Act (JPTA), United States Department of Agriculture (USDA), Social Services Block Grant (SSBG), United States Department of Health and Human Services (HHS) grants, etc.]. Some states have addressed this potential for confusion (i.e., all programs not being within a single agency) by forming a supra-agency task force. Other states with greater benefit levels through state and local taxes are less reliant than Mississippi on federal aid for relief.

The GAO, CfED and MDRC all agree there is no uniform prescription for success.

Arizona, Florida, New Jersey, Texas, Vermont, and earlier, Maine, tried to emulate the ET programs in some form. They all failed, with one major lesson that "too much, too soon" was ill advised. No one pretends to have all the answers to welfare reform, with the consensus being that pilot projects in a variety of settings are the best way to proceed.

As stated above, interagency turf battles inhibit reform proposals and even among cooperative agencies confusion is inevitable. Mississippi's effort will benefit if department heads (i.e., Departments of Mental Health, Health, Welfare, and Economic Development) are kept informed, remain enthusiastic, and periodically participate in group meetings and decision making. We will be stymied without the strong support of these Commissioners/Directors, and, even with their support, will face a certain amount of confusion.

We will also need the active support of elected officials. This political asset should not be underestimated, for it has a positive effect on the willingness of businesses and lending institutions to be involved in the SEI.

Successful SEIs have had "hardnosed" business men and women involved in the review of proposals. An entrepreneurship program in Great Britain requires hopeful entrepreneurs to go through a day long seminar on the realities of entrepreneurial activity

where businessmen relate their experiences. This has proven to be a useful screening process.

Managerial training is especially critical for new business people. All the self-employment initiatives reviewed stress a lenghty "preparation for the business world" class and/or continued support for the infant enterprise. Atlanta's Save the Children Federation trains welfare mothers to become qualified day care providers and uses proceeds from contracts to help them with state registration and other regular paperwork. Women's Economic Development Corporation (WEDCO) in Minnesota has recently begun its Self-Employment Training Opportunities (SETO) project for welfare mothers, a six month business planning and personal effectiveness training course.

Contracting with private non-profit groups to implement initiatives can achieve several valuable results. Massachussetts' Transitional Employment Enterprise, Inc. (TEE) cuts down on a business' paperwork in hiring new, often risky employees. For a fee, TEE will recruit, screen, train and place Aid to Families with Dependent Children (AFDC) recipients for their business clients. TEE keeps up with the progress of the individual and counsels them as problems arise. After four to five months, the AFDC recipient moves from the TEE payroll to the company payroll. TEE provides a "Kelly Services" type function. TEE is funded by a combination of company fees, AFDC grant diversions and state appropriations.

Welfare Reform with lasting impact is not cheap. Studies conducted by GAO and MDRC indicate that the "hard to employ" require a significantly greater investment per person than traditional job search or training services. When comparing Mississippi to other states, we should note our low levels of Medicaid, AFDC and Unemployment Insurance benefits. Even if we were able to divert 100% of these sources to the SEI, the pool of monies would be much smaller than in other states. It should also be remembered that SEIs have a lengthy payback schedule. The most successful SEI to date took six years before it was self-

sufficient. [Novia Scotia's Human Resources Development Association (HRDA)]. All available information suggests that all of the "success stories" require infusions of state appropriations over an extended period of time.

Sources of Monies

- Social Services Block Grant (SSBG) is used in New York, Wisconsin, Colorado, and Iowa to provide subsidized child care.
- Job Development and Training (JDT) funds are used in a variety of ways. JTPA Title III (Dislocated Worker) dollars are used in Ohio for enterpreneurial service training delivery. Comprehensive Employment and Training Act (CETA) funding, before the demise of the program, was used in Florida to fund market feasibility studies as well as other initial business expenses for self-employment training.
- In rural North Carolina, a Community Service Block Grant (CSBG) of $150,000 established a guaranteed loan fund for business startups by the disadvantaged.
- In California, surpluses in the Unemployment Pension fund were used to finance targeted worker retraining.
- Grant diversions constitute the greatest source of funding for welfare reform. AFDC funds have been used to subsidize training in nearly every project thus far. Medicaid dollars have the potential for subsidizing a private group health care plan among a group of self-employed in pilot projects.

New York takes a slightly different approach in its Training and Employment Assistance Program (TEAP) by not targeting the severely disadvantaged. The employer pays the AFDC recipients the prevailing wage (subsidized by TEAP) for up to six months while training them in specific jobs. TEAP is a lot like Mississippi's On-The-Job Training (OJT) component of the JTPA programs.

However, they seem to do a better job of marketing their services and reducing the paper work for interested businesses.

V. SOCIAL SERVICES IMPACT ON SEI

If reducing transfer dependency is the goal of employment initiatives, transfer payment programs must make the longer term investment required to enable recipients to earn higher wages. This investment may include improving educational levels, economic opportunities, job training and placement programs in the state. It may also include helping individuals bridge the gap between total dependency and a job paying sufficient income by providing child care, housing, or even benefits on a sliding scale basis during the minimum wage or low income phase of the path to self-sufficiency.

Caseworkers in southern states have found that even recipients who eagerly want to avoid dependency and take minimum wage/low paying jobs will end up back on the welfare rolls when a child becomes sick or when they must live on a paycheck, less taxes and child care and without housing assistance, food stamps and health coverage. For single heads of households, low paying, minimum wage jobs result in less adequate income and less security for the household than welfare dependency does.

In order for a person to establish their own business, certain support services must be in place. For an AFDC mother with a child under age 5 and no family close by, these support services generally must be furnished by the government or some social/human service agency. Two major services are needed to allow the person the opportunity to succeed or fail at their own business. Child care and transportation (mobility) are both necessary in order to embark on this effort.

Transfer payment recipients who are mothers of dependent children cannot attempt self-employment without quality, affordable child care. Full time day care services are expensive if purchased from a private operator. The cost for full time weekly care of one child can range as high as $35.00, and $55.00 per

week for two children. In the 15 sample counties for the initiative, approximately one-fourth of the AFDC mothers have children under age 6.

Subsidized day care facilities do offer their services at low to no cost. The availability of these facilities is limited (41 statewide) and the possibility of vacant slots is small as they all operate at a 90% or above utilization rate. Even though subsidized day care slots are limited, there are day care services available at full price. According to the potential maximum enrollment for child care services by the Department of Health, all day care facilities are not operating at capacity. The space available is ample to work out child care arrangements at a charge. This disincentive remains with the high cost of daycare and the low paying returns in the first year of a self-employment initiative.

Less expensive child care alternatives do exist (e.g. family, neighbors, or friends), but these may not be cheap, or available and may be substandard. This alternative for child care could possibly be the only option available to persons in rural areas.

Sickness or other unexpected situations with children will increase the difficulty of being self-employed. A sheer desire to survive and improve one's self-sufficiency will be the motivation for success in the business arena.

Several incentives should be attached to day care services for participants in this project. Recipients should be assisted in making arrangements for convenient, quality, and dependable child care if an organized child care program is not available. Priority should be given to project participants at subsidized child care facilities. Income earned during the first year should not affect any child care assistance received. Since our greatest opportunity lies with young mothers with children under three, child care at reasonable rates is necessary before SEIs

can be successful. Most states subsidizing child care for classroom job training, OJT, or other reform measures, use SSBG funds. Massachusetts, Florida, New Jersey, North Carolina, Minnesota, Pennsylvania, California, and Michigan have used state appropriations to fund child care for targeted groups. Several states utilize a sliding fee scale for lower income working mothers.

Atlanta's Save The Children program used JTPA funds to train recipients to provide child care and make referrals to them. USDA dollars paid for the children's meals (and preparation of them) in these recipients' homes. JTPA now contracts with Save The Children for slots.

California, North Carolina, and New Jersey have utilized AFDC funds to train recipients for the child care business. The benefits include self-employment for AFDC recipients and lower cost and more numerous day care providers for the work force.

Transportation is another aspect of employment that is essential. In Mississippi, if one does not have his own transportation, it is highly unlikely there will be any public transit system available except in the Jackson city area. When taxis are available in smaller, more rural towns, the costs are generally prohibitive. Transportation is funded as a social service but is restricted to the elderly or handicapped. It is very unlikely this service could be adapted to meet the needs of self-employment. Mobility is a must.

Thus, for social service support in self-employment, the two major barriers are the availability of appropriate services and the income factor for eligibility. How each is addressed depends on the needs of the individual, services available and income projected.

VI. IMPLICATIONS OF MEDICAID BENEFITS

A major barrier in moving people off AFDC is the fact that these people will also lose their Medicaid benefits. Providing

needed health care services for children can be especially expensive when paid out of pocket. Federal laws require health insurance benefits for companies employing more than 15 people, and only for full-time employees. Many AFDC recipients that could find jobs would be working part time or for small companies and thus have no insurance. Purchasing health insurance as an individual is too costly, especially for minimum wage workers.

Mississippi has gradually expanded Medicaid benefits for people above the AFDC levels (50% of poverty). Coverage is now available up to 100% poverty level, but only for pregnant women and their children up to age 5.

Mississippi has an extremely large group of AFDC recipients. When we look at the levels of payment these families receive, often barely over $100 per month for a mother with two children, it is difficult to understand why any job would not provide more for the family. Especially in a family with young children, the benefits for Medicaid eligibility outweigh the cash payments. The Mississippi Department of Public Welfare (DPW) determines eligibility for AFDC taking into account all sources of income and personal holdings. Children are eligible if family income is less than 50% of the poverty level. Everyone eligible for AFDC is automatically eligible for Medicaid. Services provided by Medicaid include routine physician visits, drugs, and hospitalization for children.

For the self-employment initiative to be successful, a transitional period is needed for AFDC recipients. This would allow the clients to receive all benefits as they begin training and start a business. This would give them a much better incentive to consider self-employment, as well as a cushion for the startup months in which few businesses make money.

A waiver of current federal guidelines is necessary in order to allow continuation of benefits as the clients borrow startup

funds and begin to make money. The DPW Commissioner must petition HHS for such a waiver. The AFDC waiver is sufficient to ensure continued Medicaid benefits.

Montgomery County, Maryland, uses a system whereby AFDC recipients in training slots (or soon to be employed) who are presently eligible for Medicaid, participate in a private non-profit health insurance plan. Their premiums are subsidized by Medicaid, counties, employers (when work begins) and other private sources. The administration of this system is handled by the Center for Prepared Health Care Research. Once the individual goes to work, she gradually assumes premium payments in proportion to her income.

Massachusetts' TEE program pays for the worker's health insurance while she is in the four to five month transitional phase (since technically she is still part of the AFDC program). Upon moving to the company payroll, the new participants join the private sector health plan (normally subsidized by the employer).

We have little information about health care plan for SEI projects. However, the group insurance concept as implemented in the demonstration counties should be explored. If participants are attempting to form a consortium for child care services, for example, participants could negotiate a group rate through a loosely connected business entity.

The state could also exercise its option to extend Medicaid coverage for an additional five months past eligibility.

VII. THE JOB TRAINING PARTNERSHIP ACT RELATIONSHIP TO THE SELF-EMPLOYMENT INITIATIVE AND EDUCATION/JOB TRAINING

In designing a program to serve welfare recipients, services under the Job Training Partnership Act (JTPA) may be used to develop a self-employment initiative or train and place welfare clients in private sector employment.

JTPA provides training and support services to the eligible population. Under a self-employment initiative, training can be offered to enhance existing vocational skills, provide a new skill, provide management and business training, support counseling, and other supportive services.

Welfare recipients entering a self-employment initiative program could be assessed under JTPA to determine skill levels, interest or basic education deficiencies. To a limited degree support services such as transportation and child care may be made available which would enable the recipient to participate effectively in the initiative. Marketing the program to obtain employer and community support is also allowable.

For those recipients who choose not to participate in a self-employment initiative, referral to existing JTPA training programs, literacy or GED programs would be appropriate. Innovative voucher systems and other employee incentives to train and hire welfare recipients may be initiated with non-JTPA dollars. The list of programs and services below outlines the opportunities available under JTPA.

Program

- Institutional Skill Training - Technical skills training and information required to perform a specific job to upgrade skills (for a class or individual). Jobs are developed for those who successfully complete the program.

- Other Classroom Training - Basic education in such areas as math, English, high school equivalency, and job keeping skills.

- On-the-Job Training (OJT) - Immediate employment for an individual, with the employer reimbursed 50 percent of the wages during the training period.

- Customized Training - Skills training conducted by an employer or third party for a specific guaranteed job opening.

- Work Experience/Tryout Employment - An opportunity for people entering or reentering the labor market to familiarize themselves with the world of work and career opportunities. Work experience opportunities are developed in public or nonprofit organizations, while tryout employment opportunities are developed in the private sector.

- Other Programs - Special programs for youth, dislocated workers, and others with unique problems in finding and keeping jobs. Such approaches consist of some combination or variation of the other programs.

Services

- Outreach and Recruitment - Finding appropriate individuals to participate in the programs.

- Assessment - Determining individuals' skills, interest and aptitudes in order to match them to training or job placement.

- Employability Counseling - Providing ongoing support to help individuals develop the skills and attitudes which will enhance their ability to obtain and retain jobs.

- Supportive Services - Offering services such as health care, transportation, child care and direct financial aid (need-based payments) that may be necessary for people to participate effectively in programs.

- Job Development and Placement - Locating jobs in the community and matching people to those jobs.

JDT and Unemployment Compensation regulations should be altered to allow educational seminars on entrepreneurial activity

to qualify as job training. Ohio has gone so far as to fund (through JTPA Dislocated Worker Program) seven pilot projects for training for self-employment. At the very least we should not count scholarship aid, low interest student loans or even "work study" as income in the calculations for eligibility. The list could be expanded to include money set aside for books, transportation, meals at school, tutorial expenses etc., upon presentation of receipts to the caseworkers.

VIII. THE DECISION TO ESTABLISH A BUSINESS

The decision to start a business is conditioned by the individual's perception of two factors: (1) the desirability of owning a business; and (2) the feasibility of doing so. The desirability of owning a business is influenced by family background, work experiences, cultural values, influence of peers, and mentors who can show the way toward self-employment or business ownership. These items constitute a social and cultural environment that may make business ownership more attractive. Some writers assert that social systems which place a high value on innovation, risk-taking, and independence are more likely to produce entrepreneurs than a system with contrasting values. Many Americans express the desire to own their own firms, although smaller proportions actually follow through on their idea. Desirability does not absolutely determine whether or not particular persons will want to start a firm but makes it more likely that they will follow through to business ownership.

A person's perception of the feasibility of owning a business is conditioned by the situational factors surrounding them at a given time in their life. Feasibility has to do with things such as the availability of role models, having mentors or partners with which to share the business idea and seeing other individuals who are perceived as no smarter starting and succeeding in business. Having financing available and finding support for other phases of the business, such as product design, marketing, and organizational issues are also important. Studies have found that people who own businesses very often had a parent or

other relative who owned their own business. Immigrant populations, such as Chinese, Cubans or Vietnamese, where they are concentrated and are able to develop social support networks have high rates of business startup.

There are several implications for the welfare self-employment demonstration:

- Cultural and family background factors are important and should be considered when individuals are selected as participants. After we have a pool of interested individuals, part of the screening process could involve questions about family or others close to the individual who may have had their own business. It would be useful to select some individuals who have the background for business ownership and others who lack it. We do not want to exclude people with a desire to own a business, but we may have more success with people who could tap experiences they or others close to them may have had in small business ownership.

- We cannot treat our would-be entrepreneurs as isolated individuals but must seek to establish a network of relationships that will help them form their idea into a workable business and get it off the ground. Organizations which provide self-employment training find that during a ten or fifteen week course, class members can develop such a support network. In other locations, individuals who locate in business incubators develop a camaraderie and tendency to share business ideas and solutions. Regions of the country, such as the Silicon Valley and Boston's Route 128, that display high levels of startup activity also show high levels of movement of people and ideas between organizations and businesses in the area. The furniture industry in the Tupelo area displays a similar tendency to copy and spin off ideas and businesses. We may want to consider designing the project so that natural support networks

can be supported or facilitated during the course of the project.

Business Birth and Death Rates

The rate at which new businesses are started fluctuates from year to year and across different industrial categories. Births as a percentage of existing establishments have been found to vary from zero up to 20 percent and higher. Birth rates exhibit similar patterns in the U.S., Britain and other European countries and range between eight and 13 percent.

In the Mississippi counties we have initially identified, the rate of new establishments (some of which are branch plants rather than independent small firms) fluctuated between seven and 12 percent during the period of 1980-1985. The average rate for the smaller, more distressed counties is at the lower end of this range and at the higher end for the larger, healthier counties. Birth rates move together in the small and mid-sized counties while birth rates in the large counties differ a great deal (See Attachment B). During the 1980-85 period, business failure rates (number of firms going out of business as a proportion of existing businesses) averaged between 7.9 and 11 percent for the smallest counties, between 8.6 and 9.9 percent for the mid-sized counties, and 8.9 and 11.1 percent for the largest counties. Other research has also found that higher birth rates are associated with higher death rates. Healthy counties still manage to grow because their birth rates exceed their death rates by a larger margin than is the case in less well-off counties.

Within the small and mid-sized counties we have initially identified, birth rates are similar and there is no clear reason to select one county over another due to a more entrepreneurial location. Among the larger counties, Rankin County seems to be clearly superior in business startup activity over the 1980-85 period. Since businessmen seem to find the Rankin economy conducive to businesses, we may want to put a project there as

well,to take advantage of any natural economic strengths that businessmen have already identified.

Self-employed Versus Poor Households in Mississippi: A Comparison

Since we are interested in helping some currently poor people to become self-employed entrepreneurs it is useful to briefly compare these two groups. The best data come from a 5 percent sample of the Mississippi population surveyed as part of the 1980 Census. While the specifics of the population will have changed since 1980, there are some striking differences in these two groups worth noting. The self-employed population is more white, more male, and better educated than poor heads of households (see Attachment C). These are not surprising findings but they point to several needs that the project will have to address, such as:,

- Remedial education may be needed for some individuals in the project. To be most useful to the individual this should be aimed at making the business a viable endeavor.

- We may want to require that individuals are able to function on at least a minimum level, e.g., 8th grade. Organizations offering entrepreneurial training find that this is a minimal level that leads to successful completion of the program. Less than 11 percent of self-employed individuals have a 7th grade education or less.

- Building the supporting networks may be more difficult for the black community since there are relatively fewer self-employed blacks in the population.

IX. CONCLUSION

In the above discussion, we have tried to present a brief but comprehensive set of ideas and facts about obtaining economic independence through self-employment investment.

Past efforts to move people dependent on AFDC into the work force have had a mixed record of success. Recently completed

evaluations by the Manpower Demonstration Research Corporation (MDRC) of employment programs for welfare recipients in San Diego, Baltimore, and Arkansas indicate moderately encouraging results in terms of increased earnings for participants and savings in welfare cost to taxpayers. However, the positive effects are generally small and the results have not been consistent across all groups and all sites. Moreover, it is not yet clear what mix of program services and/or work requirements is optimal in achieving these results. A somewhat clearer finding is that the group most likely to be helped are AFDC women with little prior employment experience. Mississippi's self-employment initiative can be effective given that the characteristics described in the above findings are relevant in the traits of our state's welfare recipients.

Mississippi's average unemployment rate for 1986 was 11.7%; this is 4.7% higher than the national average (7.0%). In FY 1986, the average number of adults receiving AFDC per month was 44,163. The average number of persons receiving Food Stamps in FY 1986 was 490,052. The state's largest source of income is transfer payments. The state has not been able to develop an industrial base to create jobs or to meet the increasing demand of the unemployed welfare recipient. Therefore, we must find innovative ways to create jobs as we increase the training and skills development of the welfare recipients. If this is not done simultaneously, we will end up with a state of well trained welfare recipients, but no jobs for them. This led us to consider the self-employment initiative as one approach to welfare reform. The following discussion presents a brief outline of how we expect to proceed.

Selecting the right service deliverer is key to the success of the SEI. We assume, and other states agree that a private organization should provide the self-employment training. State bureaucrats do not have the necessary time or expertise to operate a program in the local community. The deliverer may be a non-profit or for-profit organization. Designing an appropriate RFP will require special attention in order to avoid eliciting

standard responses which are difficult to distinguish. The RFP and the methods used for screening the responses must be very specially designed to be fair but discerning and should include interviews and on-site visits by CfED and the Department of Planning and Policy. There are at least three (3) categories of respondents to Mississippi's RFP which will be considered:

1. An Existing Business Training Provider. A key question to be raised about this type of applicant will be how attuned it is to the needs and behaviors of the target population of welfare recipients. Sensitivity to the target population is far from enough. A major problem in dealing with an existing business training organization (i.e., university and private consultant) is adapting its current approach to business training since what this project requires is not being done in most business programs.

2. An Existing Non-Business Oriented Community Organization Willing to Move into Self-Employment Training. Groups which might apply include community-based employment and training providers and social service organizations. One assumption is that the community organization has a greater familiarity and credibility with the target population and access to support services. However, contractual agreements must be clear on the administrative responsibilities in order to prevent later community confusion during periods of organization strain. This group must be evaluated to see if they make the transition to what may be a quite different set of goals, skills and attitudes. They may not be able to handle and tolerate pressures from the community or disappointed applicants or participants to meet the set agendas.

3. An Individual or Group of Persons Interested in Starting up a New Organization. In some communities, a new, independent group may be able to avoid local

ethnic and class rivalries, organization factionalism and group mistrust, and be free to operate according to its own objectives. The key test for this category is the qualifications of the individual(s) and the characteristics of the community setting.

The CfED and the Department of Planning and Policy will need to assess the possible service deliverers to determine the best route for Mississippi to follow. This would also mean soliciting input from businessmen and local citizens with visions of a different future for the state.

As noted above, the capabilities of the service deliverer/ local contractor will probably affect the success of the program more than any other variable in designing the project. Therefore, it may be necessary to make the final site selection only after getting a sense of where the best contractors are located. Alternate sites may be identified by the RFP based on existing information--where the most cooperative local public officials are, urban/rural priorities, existing state programs which complement the project, and business climate. One important consideration in site selection is how big a population of potential participants can be reached. We expect that many more will need to apply than will end up in the program. The site selection raises questions of population density, transportation facilities, street safety, child care resources, and many other factors that we must consider at this stage.

Regardless of the range of total clients trained by the local contractor, the Department of Planning and Policy must decide who, among the Department of Public Welfare's clients, to make eligible for the program and for any regulatory waiver/ welfare grant diversion aspects of the program. Those in charge of welfare payment mechanisms will play a crucial, administrative role in this aspect of the SEI. The Department of Planning and Policy, the Department of Public Welfare and CfED must develop a plan to determine those eligible for the program.

Identifying this group will require the right outreach and intake procedures and sensitivity to the population.

Many of the welfare recipients will require personal support services beyond those needed by clients in a routine self-employment training program. How much support they need must be determined by effective assessment initially. Those with heavy personal deficits will not be ready for the program but what is "heavy" and what is "manageable" will be a line drawn by the Department of Planning and Policy and the local services deliverer. If we extend the program to less ready participants, greater attention to basic life skills will be required. We must design program components to accomplish this. Personal support services to be considered are Medicaid, child care and transportation assistance. We need to address how this assistance can be provided to program participants at all stages of the project, including the first year off welfare of those who become self-employed.

In addition to the self-employment training provided by the service deliverer, the Department of Planning and Policy will need to consider how the project participants will obtain the capital needed to start up their ventures. The small loan appropriate to self-employment (generally $500.00 or less to $10,000.00) are not usually available from banks unless special relationships are established, and even then, independent loan funds may need to be created. Self-employment training will be wasted if financing is not available. CfED can provide considerable guidance on how to design and operate seed capital funds, revolving loan funds or guaranteed funds appropriate to this level of enterprise, but we need to assess local resources, public and private, to understand the needs and the possibilities.

The Department of Planning and Policy is quite aware of the risk of such an innovative project, but given our current unemployment situation, it is a risk we must take. Such programs have been successful in other states with similar economies.

This project can be successful with solid planning, adequate resources and patience.

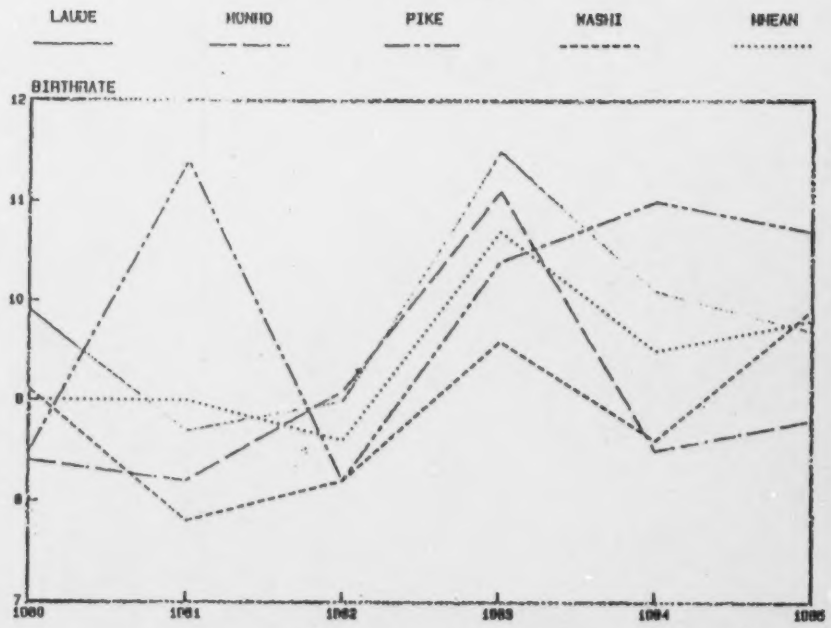
ATTACHMENT C

Characteristic	Heads of Households who were:	
	Self-Employed	Earning less than 25% above the Poverty Line
NUMBER IN SAMPLE	3870	12016
SEX		
Male	93.1%	51.4%
RACE		
Black	11.7	51.0
White	88.0	46.3
OUTSIDE SMSA	62.8	66.0
SCHOOLING		
All		
9 YEARS OR LESS COMPLETED	23.4	53.8
AVERAGE YEARS OF SCHOOL		
Blacks	8.7	7.9
Whites	12.5	9.9
Female		
COLL	34.7	11.6
ELEM	14.2	41.3
HS	48.5	45.4
NONE	2.6	1.7
Male		
COLL	38.9	13.7
ELEM	18.1	45.9
HS	42.6	38.1
NONE	0.5	2.3
PERCENT OF HOUSEHOLD INCOME FROM SELF-EMPLOYMENT		
Female	29.6	NA
Male	15.9	NA

ATTACHM B

ESTABLISHMENT BIRTHRATES: 1980-1985

MID-SIZED HEALTHY COUNTIES

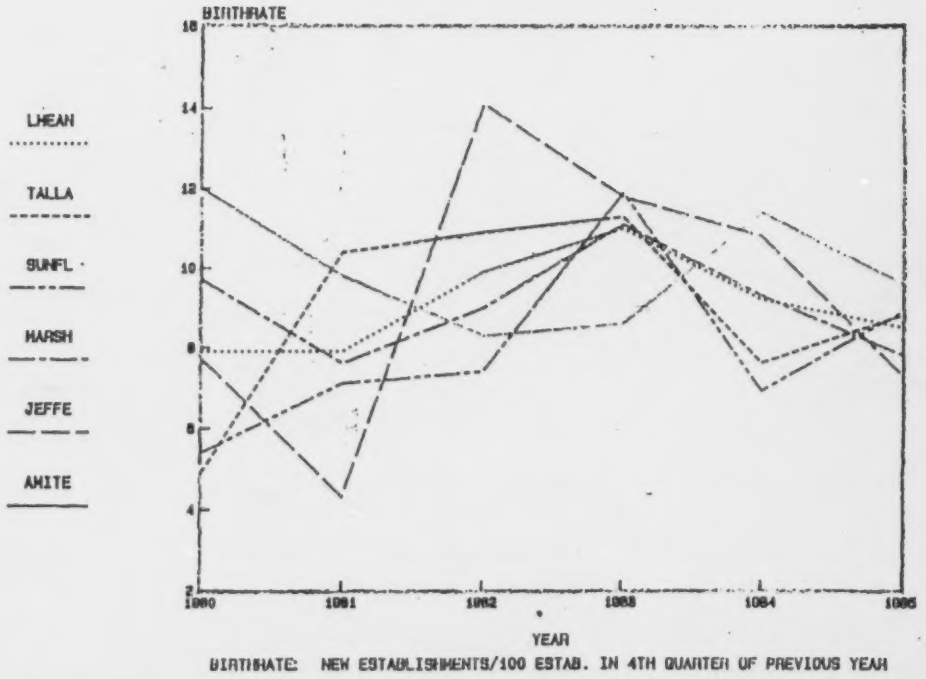


BIRTHRATE: NEW ESTABLISHMENTS/100 ESTAB. IN 4TH QUARTER OF PREVIOUS YEAR

ATTACHMENT B

ESTABLISHMENT BIRTHRATES: 1980-1985

SMALL DISTRESSED COUNTIES

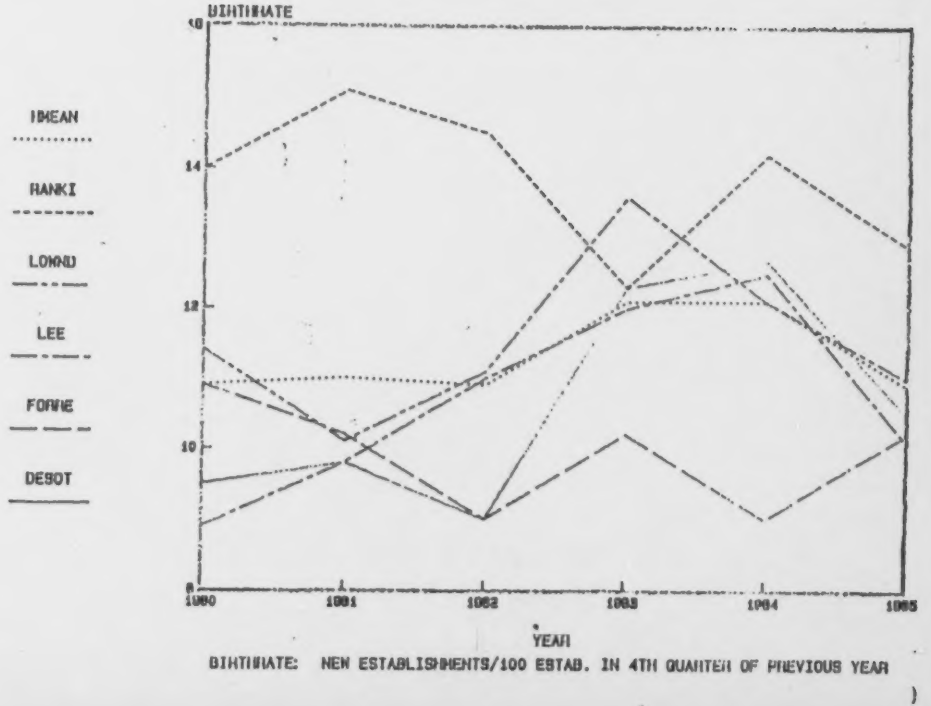


BIRTHRATE: NEW ESTABLISHMENTS/100 ESTAB. IN 4TH QUARTER OF PREVIOUS YEAR

ATTACHMENT 8

ESTABLISHMENT BIRTHRATES: 1980-1985

LARGE ECONOMICALLY HEALTHY COUNTIES



BIRTHRATE: NEW ESTABLISHMENTS/100 ESTAB. IN 4TH QUARTER OF PREVIOUS YEAR

ATTACHM
WORKSH

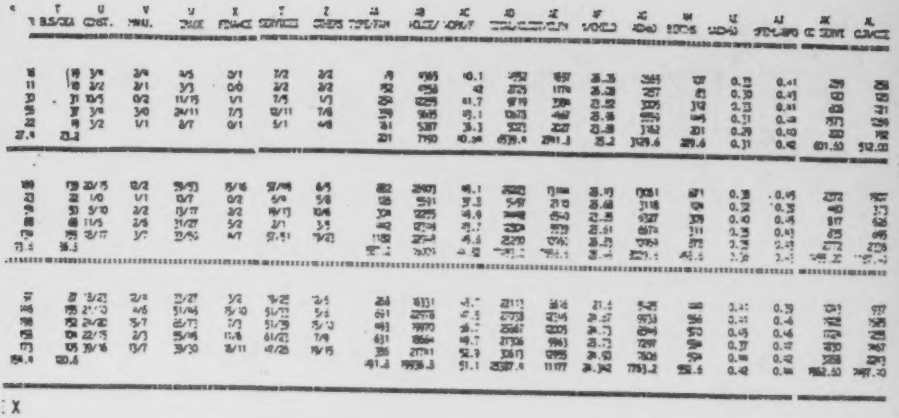
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1 COUNTY	POPULATION	RANK	AGE/M	AGE/F	EDUCATION	INCOME	UNEMP	POVERTY	SINGLE F	MARRIED	AFDC	AFDC%	FOODSTAMP	FOOD%	MEDICAID	DEATH	SOURCE
2																	
3 LOWVALLEY																	
4																	
5 WHITE	13783	62	27.7	30.9	11.1	5268	5.3	27.1	511	2797	772	5.3%	2849	19.2%	13.7	5.3	TRANS.
6 JEFFERSON	9481	77	22.5	27.7	9.9	3931	22.5	34.1	491	1470	1177	12.5%	5115	53.7%	25.7	13.5	TRANS.
7 MARSHALL	25266	26	23.9	26.9	12.7	5277	12	24.7	651	3938	2298	8.3%	9911	32.1%	15.9	13.6	TRANS.
8 CLAIBORNE	14644	21	24.3	28.3	10.3	4707	12	30	335	1589	1581	11.9%	11482	32.2%	22.1	8.5	TRANS.
9 TALLAHATCHIE	21197	53	29.1	33.2	10	4801	14	29.4	48	3736	2883	13.3%	6394	37.2%	27.5	21.3	TRANS.
10 MEAN	23548.2		24.56	28.1	10.4	4654.8	15.16	30.46	385.4	3077	2111	10.78%	6988.2	35.93%	20.98	8.46	
11																	
12 MIDVALLEY																	
13																	
14 LAUDERDALE	77225	4	27.1	30.8	12.3	7723	9.3	16.2	3749	23861	4236	5.48%	13250	15.93%	11.6	13	TRANS.
15 LEAKE	17225	52	25.9	30.1	12	5256	16.1	21.2	693	3662	978	5.66%	4694	23.31%	15.1	17.6	TRANS.
16 NEWTON	18404	13	27.1	31.3	11.9	6289	8.8	16.5	617	7080	859	4.66%	5822	15.61%	11.3	17.1	MANU.
17 SCOTT	26173	9	25.2	31	12.1	6200	8.3	21.5	859	7242	1305	4.99%	7731	21.46%	15.6	18.7	TRANS.
18 WASHINGTON	72784	5	23.3	27.3	12	5593	15.3	28.3	4258	22251	9395	12.91%	19871	27.47%	22.1	17.2	TRANS.
19 MEAN	42934.2		25.52	30.1	11.86	6294.2	11.36	22.74	2234.2	12968	3954.2	7.35%	9933.4	22.75%	15.16	16.72	
20																	
21 SOUTHEAST																	
22																	
23 OKTIBB	12930	11	25.5	27.9	12.2	7768	6.1	12.1	1291	6879	1589	2.95%	5112	11.72%	5.1	11.3	MANU.
24 FORREST	66018	7	25.4	27.7	12.4	7425	9.6	16.8	3483	19579	5091	9.99%	12916	25.77%	12.2	15.6	TRANS.
25 LEE	57081	10	26	30.7	12.1	7893	8.7	12.7	1823	19211	1689	2.95%	5279	10.29%	7.5	13.2	MANU.
26 LOWNDES	57304	9	25.1	28.4	12.1	7709	9.3	17.2	1691	19576	2887	5.21%	8208	15.22%	11.1	13.7	MANU.
27 MARION	69427	6	27.9	29.4	12.4	8507	6.2	9.3	1275	22868	957	1.38%	5528	7.96%	9.8	10.2	SERVICE
28 MEAN	60748		26.58	28.5	12.32	7859	8.02	13.62	1912.2	19018.4	2304.4	3.49%	7397.4	12.11%	7.99	12.86	
29																	
30																	

INDE

A---- NAME OF COUNTY
B---- TOTAL POPULATION (U.S. BUREAU OF CENSUS 1980)
C---- RANK OF POPULATION BY 82 COUNTY (HANDBOOK OF SELECTED DATA FOR MS 1986)
D---- MEDIAN AGE OF MALES (U.S. BUREAU OF CENSUS 1980)
E---- MEDIAN AGE OF FEMALES (U.S. BUREAU OF CENSUS 1980)
F---- MEDIAN EDUCATIONAL LEVEL (U.S. BUREAU OF CENSUS 1980)
G---- PER CAPITA INCOME (U.S. BUREAU OF CENSUS 1980)
H---- UNEMPLOYMENT RATE (MS EMPLOYMENT SECURITY COMMISSION 1987)
I---- % OF FAMILIES BELOW THE POVERITY LEVEL(HANDBOOK OF SELECTED DATA FOR MS 1986)
J---- SINGLE FEMALE HEAD OF HOUSEHOLD (U.S. BUREAU OF CENSUS 1980)
K---- MARRIED/ TWO PARENTS HOUSEHOLDS (U.S. BUREAU OF CENSUS 1980)
L---- # OF AFDC ELIGIBILES (DEPT. OF PUBLIC WELFARE)
M---- % OF AFDC RECIPIENTS OF COUNTY POPULATION
N---- # OF FOOD STAMP RECIPIENTS (DEPT. OF PUBLIC WELFARE)
O---- % OF FOOD STAMP RECIPIENTS OF COUNTY POPULATION
P---- % OF MEDICAID ELIGIBLES OF COUNTY POPULATION
Q---- INFANT MORTALITY RATE BY COUNTY (1980-1984)
R---- MAJOR SOURCE OF PERSONAL INCOME (HANDBOOK OF SELECTED DATA FOR MS 1986)
S---- BUSINESS BIRTH (MS EMPLOYMENT SECURITY COMMISSION 1985)
T---- BUSINESS DEATH (MS EMPLOYMENT SECURITY COMMISSION 1985)
U---- CONSTRUCTION BIRTH/DEATH (MS EMPLOYMENT SECURITY COMMISSION 1985)
V---- MANUFACTURING BIRTH/DEATH (MS EMPLOYMENT SECURITY COMMISSION 1985)
W---- TRADE BIRTH/DEATH (MS EMPLOYMENT SECURITY COMMISSION 1985)
X---- FINANCE BIRTH/DEATH (MS EMPLOYMENT SECURITY COMMISSION 1985)
Y---- SERVICES BIRTH/DEATH (MS EMPLOYMENT SECURITY COMMISSION 1985)
Z---- OTHERS BIRTH/DEATH (MS EMPLOYMENT SECURITY COMMISSION 1985)
AA--- FEMALE HEAD OF HOUSEHOLD WITH CHILDREN LESS THAN SIX (U.S. BUREAU OF CENSUS 1980)
AB--- TOTAL # OF HOUSEHOLDS IN COUNTY (U.S. BUREAU OF CENSUS 1980)
AC--- % OF FEMALES SIXTEEN AND OLDER IN THE LABOR FORCE (U.S. BUREAU OF CENSUS 1980)

ENT A

EET



X

AD--- TOTAL CLASS OF WORKERS IN COUNTY (U.S. BUREAU OF CENSUS 1980)
AE--- TOTAL CLASS OF FEMALE WORKERS (U.S. BUREAU OF CENSUS 1980)
AF--- % OF CHILDREN LESS THAN FIVE
AG--- # OF ADULTS SIXTY AND OLDER
AH--- # OF INFANTS BORN TO FEMALES BETWEEN THE AGES OF 15 TO 24 (MS DEPT. OF HEALTH 1985)
AI--- % OF ADULTS SIXTY AND OLDER OF TOTAL COUNTY POPULATION
AJ--- % OF FEMALE WORKERS OF THE TOTAL CLASS OF WORKERS IN COUNTY
AK--- CHILD CARE SERVICES MAXIMUM ENROLLMENT BY COUNTY(MS DEPT. OF HEALTH 1987)
AL--- CHILD CARE SERVICES CURRENT ENROLLMENT FOR 1987 BY COUNTY (MS DEPT. OF HEALTH 1987)

REPORT ON ADOLESCENT PREGNANCY IN MISSISSIPPI

July 1986

REPORT AND RECOMMENDATIONS ON ADOLESCENT PREGNANCY IN MISSISSIPPI

Developed by the Adolescent Pregnancy Task Force of the Commission for Children and Youth

Department of Human Development
Governor's Office of Federal-State Programs

July 1986

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REPORT AND RECOMMENDATIONS
ON ADOLESCENT PREGNANCY IN MISSISSIPPI

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Executive Summary

Adolescent pregnancy has always been a problem in Mississippi, but has only recently been recognized as one with significant implications for the present and future in terms of economics and human development. Dramatic impact exists for, not only the individual teen and her family, but for every member of society. As we have come to realize the loss of human potential to our society resulting from our high rate of adolescent pregnancy, it is clear that the problem demands immediate commitment and action. Individuals and families, public and private agencies, civic and community organizations, religious groups, business and labor, and state and local governments must unite for effective confrontation of adolescent pregnancy and its problems.

More than 21 percent of all Mississippi's babies are born to adolescents. We continue to have one of the highest rates of teen pregnancy in the nation. The severity of this number is emphasized by the comparison with the national rate of 13.7 percent.

Adolescent pregnancy is costly to Mississippi in both human and fiscal terms. In 1985, 355 out-of-wedlock babies were born to adolescents under the age of 15 and 5,693 out-of-wedlock babies were born to teens aged 15 to 19 years. Another 3,000 babies were born to married teens in 1985. Babies born to teenagers are twice as likely to die before their first birthday as babies born to mothers aged 20 through 29. In 1985, the infant mortality rate was 13.7 deaths per 1,000 live births. It is estimated that three times the number of babies who die live with permanently handicapping conditions, many of which could have been prevented. It costs the state an estimated $955,550 to provide a lifetime of care for one severely handicapped child.

Adolescent or teen parents are more likely to need and receive public assistance at an estimated cost of $332 million in 1984 while the first baby of a teen mother receiving public assistance is estimated to receive a total of $15,620 from the state prior to age 20.

While it is hard to place a dollar amount on the cost of a girl dropping out of school, comparisions in income levels between those girls with a four-year high school education and those who did not complete high school show that the dropouts earn an average of $2,608 less annually. During the 1984-85 school year, 432 Mississippi girls gave pregnancy as the reason they quit school. Using these figures, it can be projected that the pregnant girl who drops out of school and never returns will earn $127,792 less over an estimated 49 years of working. Projecting the lifetime reduced income by the 432 girls who dropped out of school due to pregnancy, the state is facing a potential reduction in tax base of more than $55 million for that one year's dropouts or an estimated $5.06 million in revenues to the state's general fund.

The emotional consequences of premature pregnancy include such factors as higher divorce rate for those pregnant teens who do marry before the baby is born, a higher rate of suicide and attempted suicide and a higher rate of child abuse and/or neglect. An adolescent pregnancy forces an adolescent to make decisions for herself and for the future of her baby before she is emotionally ready to make those decisions. The pregnancy strains even the best of family relationships and increases the level of stress with which all family members must cope. Additionally, studies have shown that the babies of teen parents are likely to have problems adjusting to school and often demonstrate behavioral disorders and are more likely to have lower intelligence quotients and to repeat at least one grade in school. These children also demonstrate hostility, are easily frustrated and may be uncommunicative and

overly conforming. The studies point out that additional factors such as poverty, low birth weight and poor nutrition may also be contributors to these problems.

The task force, through a study of five major areas affecting adolescents, has drawn conclusions and made recommendations which are essential to ameliorating the problem of adolescent pregnancy in Mississippi.

The family is an essential component in addressing this problem and parent/child communication is a necessity. Parents must educate themselves to understand the developmental stages of their children, particularly the adolescent period. They must increase their communication skills through available resources and acknowledge the need for open communication in their families. Parents must also accept and act on the responsibility to instill values, to develop positive self-esteem, and to teach rational decision-making skills to their children. They must teach both their sons and daughters equal responsibility for the consequences of sexual activity.

Each of us must accept responsibility as a citizen of our community and all components of the community must work together for enhancing all families' abilities to meet their responsibilities toward their children. Communities must develop strategies to help teens learn to take responsibility for their future by giving them reasons to accept responsibility and reasons to dream about their future. Expanded opportunities for career and educational choices, strengthened decision-making skills, rewarded hard work and encouragement of responsible behavior must also be included in these community strategies.

The interrelated emotional and physical health needs of the pregnant teen and her baby must be met. The families involved in these lives must also be included. Pregnant teens have special needs which must be addressed by all systems, particularly health and education, which are responsible for programs affecting teens. Programs should be comprehensive and include counseling for life planning. Proper attention to the baby's needs in the prenatal period, at delivery and after must be stressed to the adolescent parent by the systems with which the mother and baby will be in contact. The mother must understand that her actions during pregnancy and as a parent will shape her baby's future.

Since schools have the greatest amount of time and contact with the children of our state, their efforts must be directed toward providing needed alternatives to prevent dropouts, to provide specialized career development programs, and to teach parenting skills as well as family life education in a realistic manner.

There is a severe shortage of comprehensive programs in Mississippi directed toward the special needs of adolescents and teens. Comprehensive planning among public and private agencies and professional health organizations must be coordinated to address the short-term and long-range needs of adolescents for postponement of sexual activity, for prevention of pregnancy among those who are sexually active and services for those who are pregnant and/or parents and their children. Coordination and planning should include the business community leaders and should address such specific areas as comprehensive health clinics and/or school nurses, nutrition programs, financial and medical assistance, as well as the day care needs of teen parents.

This report offers a wide range of activities for everyone — from an individual commitment to collective coordination and planning; from enhancing the family role to activating groups who may not have considered themselves as part of the solution. The task force, through

research and through personal involvement and observation, understands that adolescent pregnancy in Mississippi cannot be addressed as a problem in itself. The issues of poverty, education, employment opportunities, parenting skills and life planning options must be considered also.

No one of us alone can make the needed changes or take the needed steps to ameliorate this problem, but together we can work to reduce the rate of adolescent pregnancy and the problems associated with it.

We have proposed a number of activities and programs designed to create a better future for adolescents, for children born to adolescents, and therefore, to create a better future for all of us. Some of these proposals will require strong support by the Governor and/or the various executive agencies which may have responsibility for them. Some will require funding for start-up, expansion and operation which will necessitate legislative cooperation and county and municipality commitment.

All will require that we, individually and collectively, recognize the seriousness of the problem for us both now and for the future.

Leadership will have to be provided from all arenas and from all levels if Mississippi is to break the disruptive cycle of children having children.

Introduction

In 1982, over one-half million babies were born to teenagers in the United States. Nationally, adolescent pregnancy and childbearing have emerged as a problem of enormous proportions. This has significant implications for the well-being of almost all facets of our society, including the economic, health and educational status of the general population. Indeed, the current trends in adolescent pregnancy, childbearing and parenting have the potential of exacerbating the future problems of our society by creating a substantial population steeped in poverty, characterized by congenital health problems, minimally educated, and serving as a drain rather than contributor to all other economic, human and natural resources.

Mississippi contributes substantially to this national scene. In 1984, 9,298 or 21.2 percent of all live births were to mothers under the age of twenty compared to 13.7 percent nationally. Of these teen births, 66.1 percent were out-of-wedlock as compared to 43.7 percent nationally.

These data reflect a number of problems for Mississippi. On the individual level, they indicate that many of these teens have foreclosed an array of life opportunities for themselves and their offspring. Moreover, they indicate that the natural flow of the human developmental cycle has been interrupted and life planning for and by these teens has been disjunctive and ill-informed. On a community level, the data reflect an absence of consensus regarding how to acknowledge and subsequently address the problem. At the state level, these statistics suggest that resources, both economic and human, have had to be directed toward maintenance and rehabilitation rather than toward prevention of teenage pregnancy and the forward development of the youth of our state.

Formation of the Task Force

In 1984, for the above reasons and others, including encouragement from various constituents within the general public, the Commission for Children and Youth, Governor's Office of Federal-State Programs, established a task force to review the status of adolescent pregnancy and childbearing in Mississippi and to make recommendations for programs and policies that would serve to prevent and/or lessen the problem's negative impact. Accordingly, representatives from state agencies, educational institutions, the medical profession, local civic organizations, advocacy groups, programs for pregnant and parenting teens and religious groups were appointed to serve on the task force. The task force was chaired by Martha Stennis, who also serves on the Commission for Children and Youth. While all members had input into the process, the task force was organized into four sub-committees, addressing the following areas:

Public Awareness sought to determine how well-informed the community was about the issue and ways to improve public knowledge;

Education sought to determine the current status of comprehensive health education within the schools, ways to further implement such programs, and to provide ongoing education to youth and the general public;

Health sought to determine the health status of childbearing teens and their babies and suggest ways to improve the status;

Economic Impact sought to determine the impact of teen pregnancy and childbearing on the economic well-being of the state and recommend ways to minimize the negative impacts.

Task Force Assumptions

The members of the task force held a diversity of opinions, beliefs and presumptions. However,

they shared a commonality of concern for the welfare of Mississippi's children and families. From this commonality, several basic assumptions were identified as fundamental to task force deliberations:

- Children should not have children;
- Adolescents should not be sexually active outside of marriage;
- Adolescents should be informed of the consequences of being sexually active outside of marriage;
- Adolescent parents should be provided with appropriate information regarding parenting and child care;
- Adolescents have complex health and social services needs which require unique and highly specialized services;
- Adolescent parents should be provided with counseling and education supportive of delaying subsequent pregnancies.

The task force recognizes and supports the primacy of the family in the socialization of children, and thus, directed its efforts toward suggesting programs, policies and community activities that complement the central role of the family in the development and life planning of all youth.

Adolescent Pregnancy

There are a number of myths that surround teen pregnancy. It is commonly believed that only the poor and minorities get pregnant during adolescence. Some believe that teens in Mississippi become pregnant in order to receive welfare benefits. The facts, however, are contrary to these commonly held beliefs. Adolescent pregnancy occurs among all socio-economic strata and racial and ethnic groups. Nationally the pregnancy rate for black teens is decreasing while it is increasing for white teens. Studies from other states with more liberal welfare benefits affirm that teen pregnancy rates are not tied to the amount of benefits available. The welfare "benefits" in Mississippi are such that they would hardly serve as a motivator for a lifetime commitment resulting from pregnancy, childbirth and parenting.

Adolescent pregnancy occurs among all socio-economic strata and racial and ethnic groups.

Adolescent pregnancy is diverse, complex and controversial. The task force recognizes that the ramifications of pregnancy and childbearing are probably different for an unmarried 13 year-old and a married 18 year-old; for a teen having her first baby and one embarking on her third child; for a black adolescent versus a white adolescent. It further recognizes that male and female teens approach sexuality from a variety of perspectives ranging from abstinence to frequent sexual activity with little or no understanding of consequences. The task force takes as given that no one program, policy or activity could address such a multifaceted issue.

The task force also recognizes that adolescents today receive conflicting messages regarding the role of human sexuality in their lives. The media and business advertising capitalize on sex as a subliminal motivator for buying products, attaining popularity and maintaining self-esteem while the societal/family value views adolescent sexuality as inappropriate.

Adolescence is a time of natural turbulence. It is a period in the developmental cycle when the individual is charged with the task of sorting out one's identity, coming to grips with one's self-worth and self-esteem, and importantly one's self control and ability to delay certain gratifications until later in life. This is also a

time when all of those qualities are very difficult to achieve, due in part, to maturational changes over which the teens have no control, and also due to the naturally emerging separation process characteristic of adolescence. The child is attempting to establish an identity separate and distinct from his or her parents. Oftentimes this separation process takes the form of conflict with values, attitudes and activities sanctioned by the parents. Unfortunately, sexual activity is sometimes used as a demonstration of rebellion or as the adolescent's pretense of adulthood.

The task force does not suggest a single cause for early sexual activity or adolescent pregnancy and thus, has no single programmatic response to alleviate the associated problems. As evidenced in this report, a number of actions must be initiated in concert. In order to implement these actions, state and local government, religious groups, civic and community organizations, public and private agencies, health care systems, business and labor, and families and individuals must be mobilized to address the problems and crises of adolescent pregnancy in an open and aggressive manner.

The Economic Impact of Teenage Pregnancy

Teenage childbearing cost the United States $16.6 billion in 1985, according to a study by the Center for Population Options. The 513,000 babies born to teen mothers in 1985 are expected to receive $6 billion in public assistance benefits over the next 20 years in the form of Aid to Families with Dependent Children (AFDC), Medicaid, and food stamps. This figure does not include the cost of education, special medical problems related to premature and low birth weight children, and the cost of housing, recreation, and transportation.

Using these national figures to project the cost of teenage childbearing in Mississippi, the task force projected that the 9,298 babies born to teens in 1984 would cost the state approximately $332 million or $35,700 per child.

This figure represents only the beginning of the economic burden placed upon the state. Over 70 percent of the mothers who first gave birth at ages 15-17 receive public assistance and these mothers are more likely to receive public assistance for longer periods of time; the average length of time has been estimated to be 10 years for those who start families as teens, are unmarried, nonwhite, and who drop out of school. For those teen mothers who do receive public assistance, it is estimated the first baby will receive $15,620 prior to age 20. In 1985, and in each successive year, Mississippi will add an additional $125 million of fiscal responsibility and burden to its already stressed budget.

While it is hard to place a dollar amount on the cost of a girl dropping out of school, comparisons in income levels between those girls with a four-year high school education and those who did not complete high school show that the dropouts earn an average of $2,608 less annually. During the 1984-85 school year, 432 Mississippi girls gave pregnancy as the reason they quit school. Using these figures, it can be projected that the pregnant girl who drops out of school and never returns will earn $127,792 less over an estimated 49 years of working. Projecting the lifetime reduced income by the 432 girls who dropped out of school due to pregnancy, the state is facing a potential reduction in tax base of more than $55 million for that one year's dropouts or an estimated $5.06 million in revenues to the state's general fund.

Babies born to adolescent mothers are twice as likely to die before their first birthday as babies born to mothers aged 20 - 29. Three times the number of babies who die live with permanently handicapping conditions, many of which could have been prevented. It costs the state an estimated $955,550 to provide a lifetime of care for one severely handicapped child.

Additionally, teen pregnancy today has negative implications for tomorrow's retirees. The financial contribution of today's adolescents will become even more important as our population as a whole grows older. In 1950, there were 17 workers contributing to the benefits of each Social Security recipient. Estimates are that as soon as 1992 and certainly by the year 2000, there will only be three workers.

Nearly half the children in Mississippi under six have mothers who work outside the home. For these 147,000 children, there are only slightly more than 70,000 licensed day care slots. The increasing demands that 9,000 additional teen pregnancies will place upon the child care facilities in Mississippi will soon create an insurmountable problem that will be reflected in the inability of many mothers to find adequate care for their preschool children and, therefore, reduce the options that many mothers will have in seeking employment or advancement.

Nearly one-third of the children in Mississippi were living below the poverty level when the 1980 Census information was collected. At least one-third of all births in Mississippi occur to poverty level or low income women and if the number of deliveries for which hospitals are unable to collect were considered, the percentage would be 48 percent.

The economic burden of children in poverty and of children having children cannot be underestimated nor can the need for the state to vastly increase public assistance to those children of teenage mothers who are unable to provide either sufficient income or child care arrangements. The impact of adolescent mothers bearing children will have long-term negative effects on our state. Until serious consideration is given to this problem by those with the power to develop and fund programs aimed at reducing the number of children born to teens, the economic condition of the state will continue to be critically and negatively impacted.

Teenage Pregnancy Rate*
By County, 1984

County	Rate	County	Rate
STATE	62.2		
Sharkey	114.9	Simpson	62.5
Humphreys	106.0	Lee	62.3
Sunflower	98.4	Alcorn	61.7
Bolivar	97.9	Kemper	61.7
Washington	92.0	Jefferson	61.5
Tunica	91.5	Jones	61.0
Tallahatchie	90.8	Wilkinson	60.8
Issaquena	87.8	Monroe	60.0
Coahoma	86.6	Clay	59.7
Holmes	85.6	Marshall	59.5
Scott	85.0	Benton	57.7
Winston	82.4	Forrest	57.5
Yazoo	80.2	Chickasaw	57.2
Grenada	79.6	Lincoln	56.5
Panola	77.8	George	56.0
Clarke	75.4	Pontotoc	56.0
Noxubee	74.7	DeSoto	55.7
Leflore	74.5	Lawrence	55.6
Quitman	73.3	Neshoba	55.4
Covington	71.4	Tippah	55.4
Lauderdale	70.3	Jefferson Davis	55.3
Marion	67.8	Rankin	54.4
Leake	66.6	Adams	54.2
Jasper	66.4	Amite	54.2
Wathall	66.3	Greene	54.0
Montgomery	66.0	Newton	54.0
Warren	65.6	Pearl River	53.5
Madison	65.5	Smith	53.5
Hancock	65.2	Lowndes	53.0
Hinds	65.2	Lafayette	51.0
Attala	65.0	Union	50.7
Calhoun	64.9	Prentiss	49.0
Harrison	64.9	Lamar	46.8
Pike	64.7	Itawamba	46.1
Franklin	64.5	Jackson	44.7
Webster	64.3	Tate	43.8
Copiah	64.1	Tishomingo	42.0
Yalobusha	63.8	Oktibbeha	40.2
Perry	62.7	Stone	40.2
Wayne	62.7	Claiborne	36.5
Choctaw	62.6	Carroll	35.7

**Pregnancies Per 1,000 Female Population Aged 13 - 19.*

Source: Mississippi State Department of Health
Public Health Statistics

Family and Youth Awareness and Responsibilities

While the task force recognizes teaching morals and values is a traditional family responsibility, changes in family structure, values and the economy have affected families and their abilities to perform some functions.

One measure of the changes in families is the number of single-parent families. In 1980, over 19 percent of families in Mississippi were headed by single parents and one in six Mississippi children under age 18 lived in a family headed by a single mother. Nearly 17 percent or 106,659 households were headed by females in 1980; in 1970, 70,924 families were headed by females. In 1960, the information on single-parent families was not even gathered by the Census Bureau.

The number of mothers who work outside the home also reflects changes in society and the economy. The Children's Defense Fund reports in a 1985 State Child Care Fact Book entitled "Child Care: Whose Priority?" that 54 percent of Mississippi mothers with children under age 6 work outside the home and 63 percent of Mississippi mothers with children ages 6 to 17 work outside the home. More than 244,000 or 30 percent of the children in the state live in poverty. Of these, 77,110 are under age 6. More than 45,000 or 42.5 percent of families headed by females are living below the poverty level in Mississippi.

The family environment is the first foundation in a child's life planning development. Positive self-esteem is viewed as a key to a child's successful ability to make decisions to his advantage and in processing the necessary information to deal with the world around him.

The nature of the adolescent must be taken into consideration in addressing problems of early sexual involvement and possible pregnancy and parenting. Biological maturation is only one of the dramatic events occuring during these years which are often turbulent. The teen is also faced with a major psychological quest — one for personal identity. This is a time of increased dependency on peers and the struggle to become independent of family. As a part of both these processes, teens, in their effort to be a part of their peer group and to reassure themselves that they are "normal," begin to exhibit behavior which often results in conflict within the family.

This conflict or rebellion may become confused with parental values and cause the adolescent to question and appear to reject those values. Several studies have indicated that sexual activity is often viewed as a form of rebellion against parental values and is more likely to occur as an act of rebellion in families where the parents are uneasy, anxious, and threatened when faced with sexual matters. Other explanations involving the rebellion concept are that, for the adolescent girl, becoming pregnant and having a child is a sure method of attaining independence; some adolescents may use sexual activity and/or pregnancy as a means of seeking love and support which may be lacking in their home environment.

Families in which communication is open, where there is no abuse, and where there is generally a healthy, happy parent-child relationship are at less risk for premature, non-marital sexual relationships.

Societal double standards concerning sexual activity for male and female continue to play a role in the level of responsibility assumed by teens. Greater emphasis must be placed upon both male and female responsibility for sexual activity.

Attention must be given to the "latchkey" syndrome or the lack of supervison for some children and teens. An apparent lack of organized activities can be a contributing factor to undesirable behavior in teens. Young people

who are unsupervised after school and during the summer are more susceptible to negative influences and may begin to fall behind in their school work. Supervised after-school enrichment programs greatly benefit children who may be falling behind in class work.

In order for teens to begin successful preparation for entering adulthood, they must be equipped with self-motivation, positive self-esteem, employment skills, self-sufficiency, and rational decision-making skills.

The task force recognizes the importance of parent-child communication and urges parents to become better educated in how to talk with their children and in learning about their children's development.

Societal double standards concerning sexual activity for male and female continue to play a role in the level of responsibility assumed by teens.

The Task Force Recommends:

- **Families and communities make greater use of the seminars developed jointly by the March of Dimes and the National Congress of Parents and Teachers entitled "Communications with Our Children: Seminars for Parents on Adolescent Sexuality" available from the state PTA office, Post Office Box 1946, Jackson, Mississippi 39205 or 352-7383.**
- **Parents support the development of a curriculum for teaching comprehensive health education at all grade levels in the public school systems.**
- **Parents be involved in the implementation of the health curriculum in the local school systems.**

Community Awareness and Responsibility

Community means more than family and neighbors, organizations and clubs, and church and school. It includes the media, government, service agencies, public and private institutions, businesses and advertisers, and societal leaders. It involves all of these people and it requires acceptance and assumption of responsibilities. Partnerships among and between these people and groups are essential to prevention of unintended pregnancy and in assisting those families who face unintended teen pregnancies.

While many good things are happening in communities throughout Mississippi, there is an awareness problem concerning the issue of teen pregnancy and whose problem it is. **Existing service providers** hold responsibility for addressing the needs of teens through health care, education and other services. In addition, strategies must be developed to help teens learn to take responsibility for their futures by giving them reasons to accept responsibility and reasons to dream about their future. Strategies must also include expanding opportunities for career and educational choices while strengthening decision-making skills, rewarding hard work and encouraging responsible behavior.

The community must serve as an ancillary support to the family in meeting its responsibility and in some cases assume responsibility where the family is neglectful or unable to meet its responsibility.

While all teenagers can be said to be at risk of becoming parents, studies show that one-third of teenage girls will have experienced a pregnancy before their 19th birthday. These teens, who are more at risk, must be identified at the community level and community resources must be coordinated to serve them.

Strategies must be developed to help teens learn to take responsibility for their futures by giving them reasons to accept responsibility and reasons to dream about their future.

Civic organizations, both those serving youth and adults, play an important function in the community as potential guides to young people in life planning stages. Many of the adult organizations in communities conduct service projects directed toward youth and have crucial roles in providing role models for young people, shaping values and in activating the community. Organizations should conduct a needs assessment in their communities and look at such areas as after-school and summer programs and activities for youth; sponsor learning centers and extracurricular activities designed to bolster the self-esteem of young people; offer job option training and awareness; and accept the responsibility of assisting in the life planning of young people by enhancing the teen's ability to become self-sufficient.

The **local media** must also accept its responsibility in shaping the lives of young people. Many of the role models depicted in the media, through advertising, entertainment and reporting, are poor and contradictory to reasonable and acceptable values. The conflicting messages teens receive are at best confusing. The entertainment industry, advertisers, and the advertising industry play a significant role in the community and in the direction of life planning for many teens. Local advertisers and media also have a crucial role to play in community

involvement by addressing the issues of values and family and in calling for community responsibility.

Churches and synagogues have traditionally played a major role in shaping family and community values. In order to increase this role, churches and synagogues will have to increase their partnerships with secular groups and enhance family communications by addressing necessary issues for teen life planning. Many denominations have materials available for local church and synagogue use through district or state offices. For example, the Mississippi Baptist Convention office has available a curriculum entitled "Christian Sex Education: A Resource Packet" and resource people available to conduct seminars and workshops on sexuality.

Community leadership includes, but is not limited to elected, societal and public-opinion leaders. The leaders of a community, by their example, their commitment and their focus on the life planning stages of youth can have great impact in development of positive goals and support for families and teens. In partnership with all available community resources, community leaders can identify the needs of their communities from a new angle and establish activities to meet those needs.

Recommendations:

- **Service providers in communities should coordinate their resources in addressing strategies for the prevention of adolescent pregnancies and in identifying adolescents locally who are at greater risk than other youth for becoming parents.**
- **Civic organizations should conduct needs assessments to identify and develop activities for youth in their communities.**
- **Local media and advertisers should use their editorial powers and public image to enlighten and to motivate their communities into action to address these issues.**
- **Churches and synagogues should determine what resources are available through their denominational headquarters for use with young people and utilize the materials. For example, a resource packet is available on Christian Sex Education from the Mississippi Baptist Convention Board, Post Office Box 530, Jackson, Mississippi 39205.**
- **When appropriate resources are not available, churches and synagogues should develop materials suitable for use with young people and share that material with other churches and synagogues.**

Health Issues of Adolescent Pregnancy

While the task force recognizes that pregnancy prevention is the ideal focus for family and community, we also acknowledge the existing problem and in this section address primarily the health issues of the pregnant teen, her baby and family.

The **emotional health** aspects of pregnant and parenting adolescents are often overlooked in the seemingly larger needs of physical health, but the emotional consequences of adolescent pregnancy are numerous and involve the pregnant girl, her child, the father and the parents of the adolescent(s).

The adolescent who becomes pregnant is first confronted by the traumatic decision of whether or not to have the baby and, if she decides to have the baby, whether to keep the baby or to allow the baby to be placed for adoption.

The pregnant girl must face separation from her peers at a critical period of socialization in her life. She must prematurely begin life planning for herself and her child, accepting responsibilities in decision-making far beyond her level of emotional development. Her concerns must center around continuing her education, possibly modifying her career goals, planning her financial support, finding infant and child care, and repairing family relationships which are often damaged by adolescent sexual activity and pregnancy.

The father of the child may be a teenager himself with incomplete education and lack regular or adequate income. Informal findings from programs in Mississippi serving pregnant adolescents, however, indicate that often the fathers are older teens or young adults. An Urban Institute study reports that half the babies born to teens are fathered by men over 20. The father of the child also has choices to make which include supporting the child financially or denying responsibility for the child. The percent of the teen births that were out-of-wedlock in 1985 in Mississippi was 67 percent compared to 55 percent nationally in 1983, the most recent figure available. Forty-four percent of all the babies born out-of-wedlock in 1985 in Mississippi were born to teens. Of those teens who do marry while pregnant, about 60 percent divorce within six years.

The baby also faces immediate problems including the likelihood of premature birth, low birth weight and possible handicapping conditions, as well as later emotional problems. Studies indicate that children born to teen parents are likely to have problems adjusting to school and often demonstrate behavioral disorders and are more likely to have lower intelligence quotient and to repeat at least one grade in school. Research also shows that children born to teenage mothers often demonstrate hostility, are easily frustrated, and can be uncommunicative and overly conforming. Researchers point out that other conditions including poverty, low birth weight and poor nutrition may also contribute to these problems. Recent local events have also pointed to children of female single heads of households attempting to compensate for the lack of male role models through gangs. Nicholas Lemann, quoted in the July 13, 1986 edition of "The Clarion-Ledger/Jackson Daily News," said, "A large number of fatherless families, a high unemployment rate for black teenagers—these are ideal conditions for gangs to develop." The article also stated that "a gang leader may be a father-like figure" and that gangs often give these youths a needed sense of identity and family structure that may be missing in their homes. Teen parents are more likely to abuse and/or neglect their children than older parents.

The pregnant adolescent's parents must often bear much of the financial responsibility of the pregnancy and assist the adolescent in making arrangements for the delivery of the baby. The pregnant girl is often in a single parent family setting herself and may rely on her mother to a great extent for rearing the baby.

Recommendations:

- **Individual and family counseling be provided for all pregnant teenagers which includes parenting instruction, health care both during and after pregnancy, resolution of guilt and ambivalent feelings, low self-esteem, education and employment goals, financial services and support, and family planning discussion including effective contraception.**
- **Counseling and guidance services be provided for the young fathers with emphasis on more responsible sexual practices, assumption of financial responsibilities, and resolution of guilt and ambivalent feelings.**
- **Group or individual counseling be provided for the families of pregnant adolescents to encourage their emotional support of the adolescent.**

With early and continuous **prenatal care**, the immediate health problems of the mother and baby can be decreased. Premature delivery and toxemia are the two complications of teenage pregnancy which occur in higher incidence regardless of the prenatal care provided. If the adolescent receives good health care, the rate of all other complications are no higher than in older pregnant women. Early prenatal care depends upon early diagnosis of the pregnancy and easy access to medical care.

Recommendations:

- **Adolescents be educated to the symptoms of pregnancy and the importance of seeking medical diagnosis and care when pregnancy is first suspected. Emphasis must be placed upon confidentiality and promise of health benefits from early medical care in pregnancy. Warm and supportive medical and nursing personnel are essential and special attention must be given to the important rules of self-care.**
- **The State Medical Association and the State Department of Health combine resources to conduct seminars for physicians, nurses, and midwives on the special needs of teenage mothers, emphasizing the importance of nonjudgmental attitudes in all professionals in order to further encourage cooperation from the patient.**
- **Adolescents be educated in methods of gaining access to the health care and social service system in their area, and then encourage their fullest use.**
- **Comprehensive health education and services be provided statewide in school settings for health screening and referral that these services also include qualified counselors and/or social workers.**

With proper access to medical care and adequate prenatal care, the delivery of the infant should present minimal risk to mother and child. The frequency of premature birth to adolescent mothers requires the availability of facilities to care for high risk babies when the mother is under the age of 21 years.

Recommendations:

- **Medical, nursing and certified nurse midwife personnel be educated on the importance of providing access to high risk care units upon delivery of high risk infants.**
- **Expansion of high risk care facilities in a regional fashion in order that survival rates in teenage deliveries may be increased statewide.**
- **The Governor's Office and the Legislature support one central source for perinatal education through the University of Mississippi Medical Center. Approval of any state or federal dollars statewide for perinatal education should stipulate coordination with University Medical Center and use of this common curriculum or protocol.**

If any complications of adolescent pregnancy occur, immediate referral should be made to medical facilities providing full care for the high risk infant and mother. Careful followup visits for postnatal care should be required and family planning education, including contraceptive counseling, should be included in postnatal counseling.

Recommendations:

- **Medical personnel be educated on the importance of emphasizing personal values and priorities as deterrants to future pregnancies when counseling adolescents.**
- **The young mother and father be educated in alternative methods of contraceptives, including abstinence from sexual intercourse as one birth control method.**
- **Parenting education, including the growth and development stages of the child, be provided.**
- **A follow-up system be established which supports positive goals for the future and utilizes all available agencies and appropriate individuals.**
- **The establishment of school health services at all levels of public schools. These services can be as comprehensive as a full health screening and referral clinic or as basic as a nurse and trained counselor/social worker.**
- **Professional organizations in the health fields accept the responsibility of assuring access to medical care on the local level and identifying the current levels of access for adolescents.**
- **Parenting support groups be established at the community level to aid the teen parent in caring for his/her child; to encourage the prevention of the second pregnancy; and to aid the teen parent in establishing a positive direction for the future.**

Education

Education is more readily identifiable as the cornerstone in the life planning of a teen. Pregnant and parenting teens often find themselves off-track educationally and face obstacles in getting back into the educational system. Studies have also proved a direct connection between the rate of teen pregnancy and poor academic achievement. Adolescents with the poorest basic academic skills are five times more likely to have a baby before the age of 18 than those with average skills. Many school districts have recognized the benefits of alternative programs which also address the special needs of these teens.

Of the 11,608 students who dropped out of school in Mississippi in the 1984-85 school year, 432 cited pregnancy as the reason. One fifth grader, seven sixth graders, 25 seventh graders, 68 eighth graders, 89 ninth graders, 101 sophomores, 77 juniors, 50 seniors, and 14 unclassified students gave pregnancy as the reason they dropped out of school. Another 306 dropped out because of marriage while nearly 3,500 dropped out for unknown reasons.

While it is hard to place a dollar amount on the cost of a girl dropping out of school, comparisons in income levels between those girls with a four-year high school education and those who did not complete high school show that the dropouts earn an average of $2,608 less annually. During the 1984-85 school year, 432 Mississippi girls gave pregnancy as the reason they quit school. Using these figures, it can be projected that the pregnant girl who drops out of school and never returns will earn $127,792 less over an estimated 49 years of working.

Comprehensive health education has been a goal of the task force since its inception and with the leadership of advocacy groups, state agencies, and key legislators, the Board of Education approved the development of a curriculum. A task force was appointed by the Superintendent of Education in May 1986 to begin the curriculum development. The Adolescent Pregnancy task force will be represented on this Education Department task force.

Statistics show that more adolescents are getting pregnant at earlier ages, many without knowledge or understanding of the consequences of their actions. Studies by the Guttmacher Institute, comparing the teen pregnancy rate in the United States with other countries, have shown that U.S. teens are not more sexually active, but less likely to use contraception. Education and the availability of contraception are reflected in teen pregnancy rates of the countries studied. The U.S. teen pregnancy rate far surpasses the rate of other nations of the Western world.

With a clear understanding of good health practices, encouragement to postpone sexual activity, personal responsibility for healthy life planning and clear reasons to delay parenthood, teens will have a clearer concept of the consequences of sexual activity and possible pregnancies to their futures. Special attention should be given to the teen male and his need for information and life planning goals.

The function of school counselors is currently perceived as strictly academic, testing and working with college-bound students. Students need a trained professional who can work with them in all phases of life planning using a case management approach to the real problems many students now struggle with alone. The school is the single institution in contact with the largest number of children and youth in the state and is the institution with the most opportunity and potential to impact on children in Mississippi.

Programs which work specifically with pregnant and parenting teens in job-training are necessary in the existing educational system.

Research cited in the Children's Defense Fund Budget Analysis for FY '87 indicates that "teens from low income families, regardless of race — teens with poor basic skills and poor employment potential — face higher risks of early parenthood." The same document also says, ". . .too many of America's poor and minority youths who have no hopes for better futures become parents too young because they do not think they have anything to lose."

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In Mississippi, the Department of Job Development and Training which administers funds of the Job Training Partnership Act (JTPA) has made teen parents a target group and sponsors two programs exclusively for teen parents which combine job training with educational attainment.

Alternative education programs can play a significant role in helping pregnant and parenting teens stay in school. Programs often incorporate instruction in the health care needs of pregnant teens and parenting training as well as continued academic courses to allow the teen to keep pace with course work. Some programs combine day care features with job training and parenting skill courses.

The Hattiesburg Alternative Program provides alternative education to pregnant students through regular school funding, while the Jackson-Hinds Comprehensive Health Center is funded through both federal and foundation grants and provides comprehensive health care to students in five junior high and high schools. Infant and child day care programs are provided so that the student/parent can continue her education. The MACE Teen Parent Center in Greenville works to help the pregnant and parenting adolescent continue her education, develop employment and parenting skills, delay subsequent pregnancies and ultimately achieve economic and personal self-sufficiency. The Teen Learning Center in Meridian provides short-term instruction to help prevent students from dropping out of school during stress periods, including pregnancy and parenthood. There are other programs in the state, many of which are listed in the task force's "1985 Survey: Mississippi Services to Pregnant and Parenting Teens."

Few parents, teen or adult, receive formal training for the important function of parenting. Teen parents are at greater risk to become neglectful and/or abusive. Training and support of their role as parents are essential elements in the life planning development of both the teen parent and the child.

Recommendations:

- **Teens who are sexually active and at high risk for becoming parents and for dropping out of school need trained professionals to work with them in all phases of life planning in a case management approach.**
- **Schools establish academic remediation programs at elementary and junior high levels to avoid academic failure which often leads to dropping out, to premature sexual activity and pregnancy.**

- Alternative educational programs are needed to help pregnant and parenting teens complete their education.
- Job training programs directed at pregnant and parenting teens be established to help them reach their fullest potential and to be able to support themselves and their child.
- Day care be available for those teen parents who are in school, job training, or working.
- Parenting training is essential for teen parents to provide optimal environment for their children.
- Schools or communities implement an interdisciplinary approach to working with pregnant and parenting teens which includes social workers, counselors, and teachers, as well as traditional health care personnel.

Support Services

A 1985 survey of services and programs in Mississippi geared to pregnant and parenting teens revealed that services are inadequate and unevenly distributed throughout the state and that existing programs have no network through which to exchange information. There is little or no coordination through support services to identify teens who are at risk, and while there are numerous services and programs available to the general teen population, these services are not linked in any way.

The single, most effective contact with young people in this age group is through the school setting. According to the task force's "1985 Survey: Mississippi Services to Pregnant and Parenting Teens," existing **in-school clinics**, serving the complete health needs of teens, have proved to be extremely successful in identifying at risk teens, in preventing unintended pregnancies and in reducing repeat pregnancies. In-school clinics also have the capabilities and responsibilities to begin early parenting education, to provide information to pregnant teens and to encourage realistic life planning for the teen and her child. School-based clinics are the nearest thing to coordinated case management for teens, and these clinics exist in only one school district in the state.

In pilot projects coordinated by the Departments of Health and Education, **school nurses** in junior high schools provided classroom educational sessions, individual education and counseling, physical assessments and referrals. The project, in eight junior high schools, was directed to encouraging the postponement of sexual involvement by teens and, for the sexually active teen, the prevention of unintended pregnancies. Preliminary indicators are that the number of pregnancies in students decreased significantly. Sixty teens are enrolled in family planning services and 25 documented cases of sexually transmitted diseases were referred for treatment. The five nurses in the project made over 17,000 student contacts and conducted over 2,000 personal counseling sessions in a student population of 4,000.

Proper nutrition for the pregnant teen and her child are vital to healthy starts. Teens are more likely to give birth to low birth weight babies, who are 20 times more likely to die within their first year of life. Low birth weight also contributes significantly to mental retardation and other serious health problems. The age of the mother, lack of prenatal care, poor nutrition, low education and socio-economic status, smoking, alcohol and drug abuse are associated with low birth weight.

The WIC program, a Special Supplemental Food Program for Women, Infants, and Children, is designed to meet the nutritional needs of pregnant women and their children. A five-year study documented increased birth weight and brain growth among infants born to WIC participants and children directly benefitting from WIC. In Mississippi, infant mortality rates among WIC participants dropped by one-third, and the number of premature births decreased as much as 25 percent.

Financial and medical aid to pregnant and parenting teens is critical to the health of both teen and child. Thirty percent of Mississippi's children were living below the poverty level according to information gathered during the 1980 Census. The poverty level set by the federal government for 1985 was $8,850 for a family of three.

In January 1985, the combined benefits in Mississippi represented 41.1 percent of the poverty level or $303 per month for a family of three. According to information from the Children's Defense Fund '87 Budget Analysis, in January 1985, Mississippi ranked last in

monthly AFDC and food benefits as a percentage of monthly 1985 federal poverty level. One month's AFDC payments in Mississippi totaled $698,148 in April 1986. This assistance went to 9,873 children in the state in 7,447 households. No information is available on how many of these households are headed by teen parents; however, many of the pregnant and parenting teens are reflected in the 9,873 children who received assistance. Current assistance rates are $60 for the first child, $36 for the second child and $24 for each additional child with the parent or guardian also receiving a $24 allotment.

Effective July 1, 1986, the standard for determining eligibility for AFDC/Medicaid and for Medical Assistance was increased to 50 percent of the poverty level. The Medical Assistance program provides prenatal and delivery services to pregnant women and outpatient and inpatient care for their children up to age 18. It is available to any pregnant woman, married or unmarried, who meets the income criteria and to children in a low-income family and children of a teenage parent. In order to qualify, a family of three cannot have more than $369 in monthly income as of July 1 — that's an increase from $286. Children of teenage parents need only count the parent's income, not their grandparents', to qualify. In June 1986, 6018 children and 798 pregnant women received assistance through the Medical Assistance program. Under new federal legislation, Medicaid is now mandated to cover all pregnant women with family incomes and resources below the state AFDC financial eligibility levels; an additional 60 days post-partum coverage is provided for all women whose Medicaid eligibility is based solely on pregnancy, even if they would not otherwise be eligible for Medicaid once their pregnancies end. In addition, any Medicare-funded hospital facility is prohibited from refusing to treat, or appropriately transfer, emergency patients including those in active labor. This law also permits states to provide pregnant women with enriched Medicaid benefits. Studies show that more comprehensive Medicaid benefits during pregnancy lead to better birth outcomes and reduced Medicaid costs.

National statistics show that teen mothers are more likely to receive public assistance later in life. Approximately 72 percent of the mothers who first gave birth at ages 15-17 are receiving public assistance. A soon-to-be published study by a sociologist at the University of Pennsylvania indicates that teen mothers often recover socially and financially to a much greater extent than is commonly expected. While they face great disadvantages compared to women who have children later in life, sociologist Frank Furstenberg's study, which followed the progress of 300 black, adolescent mothers from Baltimore and their children for 17 years, shows that many manage to overcome these obstacles through three significant

The offspring of teenage childbearers are doing substantially worse academically, emotionally, and socially than the children of women who had their first child after age 20.

The adolescent mothers in the study who participated in health care and family planning services combined with a high school program involving instruction, counseling and child care education were substantially more likely to avoid welfare dependence and limit their family size in later life.

ways: pursuing their education, limiting the births of subsequent children, and achieving a stable marriage. The study found, however, that the children of these adolescent mothers often demonstrate serious adjustment problems in their teen years. "The offspring of teenage childbearers are doing substantially worse academically, emotionally, and socially than the children of women who had their first child after age 20," the report says.

"The adolescent mothers in the study who participated in health care and family planning services combined with a high school program involving instruction, counseling and child care education were substantially more likely to avoid welfare dependence and limit their family size in later life," Furstenberg said.

Recommendations:

- **Comprehensive planning among private and public agencies and professional health organizations be coordinated to address the short-term and long-range needs of adolescents for postponement of sexual activity, for prevention of pregnancy among those who are sexually active and services for those who are pregnant and/or parents.**
- **The State Department of Public Welfare actively seek available federal funds for maternity services for teens in addition to those currently available through AFDC/Medical Assistance/Medicaid.**

Summary

Services currently being offered to at-risk teens, pregnant teens and parenting teens are inadequate and unevenly distributed in the state and there is no network for existing programs to exchange information. Few of the programs are designed comprehensively or specifically to meet the special needs of teenagers.

The existing services, public and private, are not linked for referral or coordination. Case managers are not available to teens. There is no systematic approach to identifying teens at risk of becoming sexually active and/or pregnant. Random attempts are made in the Early and Periodic Screening Diagnosis and Treatment program or in family living courses through Home Economics curriculums in most high schools to provide basic reproductive information to teens.

A core service support system which would work to identify at-risk teens; provide services to those teens as well as to pregnant, parenting teens and their families; and provide complete services for life planning through a case management approach will require great coordination and support within the service delivery system and is essential to ameliorating this problem in Mississippi.

Leadership will have to be provided from all arenas and from all levels if Mississippi is to break the disruptive cycle of children having children.

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1983 Percentages
Low Birth Weight* Babies

	United States	Mississippi	Mississippi Rank Among States
All Low Birth Weight Babies	6.8	8.8	50 of 51
White	5.7	5.9	33 of 51
Non-White	11.4	11.9	32 of 48***
% of All Teen Mothers Having Low Birth Weight Babies	9.5	11.3	48 of 51
White Teen Mothers	7.8	8.1	36 of 50**
Non-White Teen Mothers	13.4	13.2	15 of 40***
% All Low Birth Weight Babies Born to Teens	19.2	27.4	50 of 51
White	16.1	22.2	44 of 50**
Non-White	25.2	30.7	37 of 40***

* Low Birth Weight — Under 5.5 pounds
** Excludes District of Columbia
*** Several states have a small number of non-white low birth weight births to teens and were not ranked.

From: *Maternal and Child Health Data Book*
Children's Defense Fund, 1986

1983 Percentages
Teen Births Out-of-Wedlock

	United States	Mississippi	Mississippi Rank Among States
All Teens	54.1	63.5	43 of 51
White	39.7	21.4	1 of 51
Non-White	85.7	88.5	34 of 48*

1983 Percentages
All Out-of-Wedlock Babies Born to Teens

	United States	Mississippi	Mississippi Rank Among States
All	36.6	43.7	49 of 51
White	36.6	47.5	51 of 51
Non-White	36.6	43.2	47 of 48*

* Because of small numbers, several states were not included in count.

From: *Maternal and Child Health Data Book*
Children's Defense Fund, 1986

1983 Percentages
Women Receiving Early* Prenatal Care

	United States	Mississippi	Mississippi Rank Among States
% of All Women and Teens	76.2	74.6	37 of 51**
White	79.4	85.1	7 of 51
Non-White	63.4	63.3	31 of 51
% of All Teens	53.8	57.3	19 of 51**
White	56.9	68.7	4 of 50
Non-White	46.8	50.5	20 of 48

* Prenatal Care in First Three Months of Pregnancy
** Includes District of Columbia

From: *Maternal and Child Health Data Book*
Children's Defense Fund, 1986

1983 Percentages
Women Receiving Late* or No Prenatal Care

	United States	Mississippi	Mississippi Rank Among States
% of All Women and Teens	5.6	4.6	28 of 51
White	4.6	2.5	9 of 51
Non-White	9.4	6.8	8 of 48**
% of All Teens	11.7	8.4	13 of 51
White	10.6	5.7	5 of 50
Non-White	14.1	10.0	6 of 44**

* Late prenatal care refers to starting prenatal care in last three months of pregnancy
** States with very small numbers of non-white births are not ranked

From: Mississippi Department of Health

1983 Percentages
Low Birth Weight to Teens

Age of Mother	% of Low Birth Weight Infants
15	16.2
15 - 17	12.2
18 - 19	10.5
20 - 29	8.3

In 1984, statistics released by the State Department of Health show that in Mississippi births to teens represent 21 percent of total births.

Teen Births By Age and Race
1984

AGE	WHITE	NONWHITE	TOTAL
11	0	2	2
12	0	14	14
13	7	72	79
14	27	286	313
15	135	519	654
16	349	940	1,289
17	615	1,131	1,746
18	912	1,404	2,316
19	1,248	1,637	2,885
TOTAL	3,293	6,005	9,298

Source: Mississippi State Department of Health
Public Health Statistics

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Unintended Pregnancy-Family Planning Initiatives Costs Summary

1. Adolescent Family Life Education

A special committee reporting to the State Board of Education is developing a curriculum for all grade levels involving health education and personal decision making. The curriculum will be funded under the Department of Education's budget beginning in FY 1990.

No additional funds requested at this time.

2. Community Outreach and Education

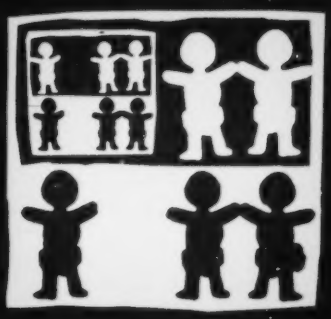
To increase the public awareness of the availability of family planning services and need for action on problems of teen pregnancy, these funds will provide for media programs as well as for seed money grants of up to $2,000 for community-based programs aimed at education for responsible family planning.

	FY 88	FY 89
State	$50,000	Continuation
Federal	-0-	Funding
Total	$50,000	

3. Public Health School Nurses

A pilot project using public health nurses to provide health education and counseling to public school 7th through 9th graders was initiated in East Central Mississippi in 1985. The cost has been $23 per student. The program, to be phased in statewide over four years for approximately 100,000 students, does not involve clinics or contraceptives in the schools. Approximately 34 public health school nurses will be added per year. The project has received widespread acceptance and support from community leaders, school staff, and students. Continuation funding will be required after FY 1991.

	FY 88	FY 89	FY 90	FY 91
State	$600,000	$1,200,000	$1,800,000	$2,400,000
Federal	-0-	-0-	-0-	-0-
Total	$600,000	$1,200,000	$1,800,000	$2,400,000



Report and Recommendations On Infant Mortality In Mississippi

Developed by the
Infant Mortality Task Force
of the Commission for Children and Youth

November 1985

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
JACKSON 39205

BILL ALLAIN
GOVERNOR

POST OFFICE BOX 139

January 17, 1986

Dr. Earl Fox
Chairman
Mississippi Infant Mortality Task Force
Mississippi Department of Health
2423 North State Street
Jackson, Mississippi 39216

Dear Earl:

I have read the report of the Mississippi Task Force on Infant Mortality carefully, and I want to commend the Task Force members for their dedication in submitting timely and thoughtful recommendations. I generally support the report and recommendations in their entirety; however, limitations on the availability of state funds during this fiscal year may delay implementation in some areas.

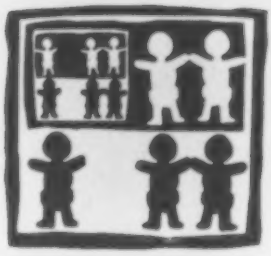
I am requesting that Mrs. Beverly W. Hogan, Executive Director of the Governor's Office of Federal-State Programs, review the report and identify those recommendations which can be incorporated within the existing state government network at no additional expense. I am also asking that she classify the remaining recommendations according to potential funding sources and the need for legislative action.

It is apparent that the Task Force members have put a great deal of effort into the preparation of this report. Please express my appreciation to them for calling these issues and recommended solutions to my attention. I feel confident that, with the support of the Task Force, we can more effectively solve the problems of infant mortality in Mississippi.

Respectfully,

Bill Allain

BILL ALLAIN
GOVERNOR



Report and Recommendations On Infant Mortality In Mississippi

Developed by the
Infant Mortality Task Force
of the Commission for Children and Youth
Nellie Hutchison, Director
Claude Earl Fox, M.D., M.P.H., Chairperson

Department of Human Development
Michael Raff, Director

Governor's Office of Federal-State Programs
Beverly W. Hogan, Executive Director

Bill Allain, Governor

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Additional copies available from the Commission for Children and Youth, 301 West Pearl Street, Jackson, Mississippi 39203-3093, telephone 601/949-2009.

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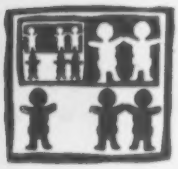
Overview of the Problem: Infant Mortality



Mississippi continues to lead the nation in excessive infant deaths, with the 1984 infant mortality rate of 14.4 deaths per one thousand live births, which is one of the highest rates in the nation.

This mortality rate is particularly notable when looking at the proportion of non-white deaths as a contributor. The non-white infant mortality rate (19.2) continues to be almost twice that of the white rate (9.9) The overall low-birthweight rate (8.4) or proportion of small babies born to Mississippi mothers is approximately the regional average: white 5.2 and non-white 11.9. The higher proportion of non-white population results in a high low-birthweight rate for Mississippi as a whole, again one of the highest in the nation. Two recent analyses on matched birth and infant death data have shown that in Mississippi:

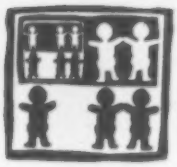
- Too many very low-birthweight babies (500-1499 grams) are being delivered in hospitals not staffed or equipped to care for these very high risk babies, increasing their risk of dying.
- Non-white infants in Mississippi have an increased risk of dying between one month and one year of age. This is a totally unexpected finding, and probably, in most instances, these deaths would be preventable with access to necessary medical care.

While the infant mortality rate itself is devastating to Mississippi's health and economic status, estimates are that for every one of the 629 infants who died in Mississippi in 1984, three times as many were probably born retarded and/or severely handicapped and may be wards of the state for the rest of their lives. The approximate cost to the state for one such handicapped individual is estimated to be $19,111 a year or $955,550 for a 50 year lifetime of care, without adjustment for inflation. If only one-third of these infants are cared for by the state, this would amount to $12 million per year.

As one can surmise, the causes of Mississippi's excessive infant death rate are multiple, and no one factor can be singled out as the major contributor. Our high incidence of teenage pregnancy, low-birthweight, poor education and low socioeconomic status, lack of access for planned delivery services and acute medical care for infants and children, and delivery in a hospital neither equipped nor staffed for high risk of mothers and infants are all important contributors. As the problems are multiple, so are the solutions.

This Task Force report is an attempt to elucidate some of the directions that should be taken by leaders within our state to address this important problem. The Infant Mortality Task Force has assumed not only the charge from the Governor's Commission for Children and Youth to evaluate the problem of excessive infant deaths and make recommendations but also has accepted the responsibilities of the Ad Hoc Perinatal Committee of the Health Care Commission with regard to standards and guidelines.

Recommendations: Public Awareness



A need exists for information to the general public, emphasizing the importance and availability of maternal and infant care and family planning services. Teenage pregnancy in Mississippi is still a major problem and in 1984 contributed to 21 percent (9,298) of total births.

Recent studies by the Alan Guttmacher Institute have shown that in countries with similar characteristics to the United States, the ready availability of health education and contraceptive services has contributed to a decrease in the number of teenage pregnancies and abortions. This is true even in countries where welfare benefits are more liberal than the United States.

In addition, in 1984, 419 Mississippi mothers received no prenatal care, and only 63.2 percent of the non-white mothers came for prenatal care in the first trimester of pregnancy versus 85.2 percent of white mothers. Unfortunately, Mississippi has one of the highest percentages of pregnant women who received inadequate prenatal care (often less than five visits) among the states in the southeast, and many mothers still do not seek early prenatal care but present themselves for delivery in the late stages of labor. Early, appropriate, comprehensive, and continuous prenatal care is critical in preventing a poor pregnancy outcome and insuring a healthy newborn. Based on this information, the following recommendations are made:

Teen Pregnancy

- **Coordination between the State Department of Health and the State Department of Education should be initiated in a statewide plan for family life education in the schools.** This plan should be comprehensive and include all aspects of health education and should not be limited to an occasional "health course." The Governor's Office should support family life education as an ongoing part of the curriculum in all public schools. Local involvement in the development of these courses and curriculum should insure local support of this education.

- **A model program currently being piloted in Mississippi which places nurses in public schools should be expanded statewide with funding through the State Department of Health and local school districts.** Establishment and funding of school-based adolescent health clinics should also be encouraged.

- **Increased awareness regarding the problem of teenage pregnancy is needed.** Statewide public service announcements regarding the problem of teenage pregnancy should be made available. Permission should be obtained from Illinois to utilize three or four of their television spots developed for the teen pregnancy campaign in that state. If untagged copies can be obtained, information pertinent to Mississippi could be added at the end of each spot. These spots should then be duplicated and distributed statewide. A toll-free phone number should be identified (perhaps the Governor's Service Line) for use on the tag. Resources for production and dubbing should be explored with interested organizations such as the March of Dimes. Television and radio stations should be asked to donate as much time as feasible to such spots and to try to place them in the prime time segments. These public information spots should also inform the public as to where resources for care are available. The State Department of Health and the Governor's Office should support and disseminate the recently developed American College of Obstetrics and Gynecology public information spots regarding the importance of a wanted pregnancy. In addition, radio should be explored as a medium for reaching teenagers. Consideration should be given to adaption of the Illinois television spots for radio use.

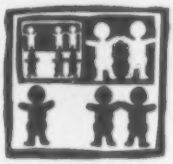
- **Financial support should be given by the Governor's Office for purchase and dissemination of additional copies of the new teen pregnancy slide presentation developed by the State Department of Health.**

- **The statewide survey recently completed on programs for pregnant and parenting teens by the Governor's Task Force on Adolescent Pregnancy should be disseminated through as many sources as possible to increase visibility regarding these services.** Many of these programs have a goal of reducing repeat pregnancies among teens.

Prenatal Care

- **Public awareness regarding the benefit and availability of early and continuous prenatal care should be sought.** Television spots, radio announcements, public service announcements, billboards, posters and newspaper articles are needed statewide to inform the population about the benefits of early and comprehensive prenatal care, appropriate and planned delivery, and ongoing well-child and acute pediatric care. Dollars should be identified by the Governor's Office to activate this campaign statewide. For example, the Coalition for Mothers and Babies is working with the Healthy Mothers/Healthy Babies Coalition in the State of New York to secure (possibly free) copies of two of the New York prenatal care campaign television spots and related promotion materials. The Coalition has made application to be one of the state organizations chosen to disseminate these spots and materials. Public service announcements and other public information should state where public prenatal care is available so that anyone wishing to avail herself of this care knows where it can be found. Locations should include public health departments, primary care centers, and charity hospitals. The Mississippi State Medical Association, the Mississippi Medical and Surgical Association, and local chapters of the American Association of Obstetrics and Gynecology, the American Academy of Pediatrics, and the American Association of Family Practice Physicians should be requested to keep a rotating list of doctors that will accept new Medicaid and/or partial pay patients.

Recommendations: Guidelines, Standards and Coordination



In a state such as ours where resources are extremely limited, it is essential that every public dollar spent on perinatal care be used to its maximum. Adequate coordination should be developed to insure that public dollars spent are not duplicated or used for untested remedies. The following recommendations are therefore made:

- **The Governor's Office has designated one entity in state government to review all federal and state funded applications under Executive Order 12372. A small group of experts designated by the Infant Mortality Task Force will review and make recommendations to the state office on all applications for federal or state dollars to be spent in the area of perinatal health.** This should include public applications coming through the health system agencies, the Health Care Commission, the State Department of Health, and others and should insure that these applications coordinate with existing services and that the new services are needed.

- **All in-patient facilities providing maternity and newborn services in Mississippi should be formally designated as to their appropriate level or perinatal care.** This designation consists of Level I, IIa, IIb, and III centers. The Infant Mortality Task Force should recommend adoption of formal guidelines for classification of these facilities, and these should be published and distributed by the Health Care Commission or its successor. Hospital classification should then be incorporated on a formal basis into the State Health Plan and also should be used by Medicaid, the State Department of Health, and any other agency looking at the use of public dollars for perinatal care. Hospitals seeking licensure or relicensure should meet the perinatal level-of-care standards.

- **Infant mortality and other pertinent perinatal statistics collected by the State Department of Health should be tabulated and compiled by public health district, by county, and by hospital of delivery.** These statistics along with analysis and commentary should be reported in a document evaluating the quality of perinatal care in Mississippi. This report should be printed annually by the State Department of Health and presented to the Governor's Office and other interested parties.

- **Any public facility seeing patients for maternity care should use a common risk-oriented record.** This should include charity hospitals, University of Mississippi Medical Center, the local county health departments, and community health centers. This record should also be recommended to any private physician seeing maternity patients. At the present time, the Hollister Record is recommended as it is being utilized by many of the groups mentioned above.

- **Confidential perinatal mortality reviews should be conducted in each public health district.** These should be held at least twice a year and should include the confidential review of matched infant birth and death certificates. These perinatal death reviews should ideally include local physician, hospital, and health department personnel. The Mississippi Chapter of the American Academy of Pediatrics, the College of Obstetrics and Gynecology, the Association of Family Practice Physicians, the Mississippi Medical and Surgical Association, and the Mississippi State Medical Association should be encouraged to sponsor or participate in such activities. The data compiled for and used in these mortality reviews should be strictly confidential and should not be available to the public.

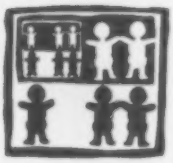
- **The Governor's Office should encourage the Legislature to immediately establish an ex-officio membership on the State Eleemosynary Board and the State Hospital Commission for two physicians, one from University of Mississippi Medical Center, and one from the State Department of Health.** These appointments would provide better coordination of care between major institutions rendering perinatal care. It is further recommended that the functions of the Eleemosynary Board be eventually transferred to the State Department of Health and the State Hospital Commission be placed with the Division of Medicaid.

- **The Governor's Office should support the phasing out of state funds for in-patient services for the state charity hospitals only when access is guaranteed by law for all patients in need of emergency care, including the emergency situation of labor. The funds currently allocated to charity hospitals should be reprogrammed to provide a funding mechanism for all poverty level patients.** Transfer of these monies to Medicaid alone will not solve the problem of access since many will still not be eligible because of Mississippi's low standard of need.

- **The Governor's Office should request that the State Department of Health in conjunction with the Mississippi Health Care Commission submit on or before October 1, 1986, a four-year plan for meeting the 1990 Objectives for the Nation regarding perinatal, maternal, and child health care and the methodologies for reaching these goals.** This four-year plan should serve as the maternal and child health portion of the State Health Plan. An update of the goals and objectives and a progress report on their attainment should be submitted to the Governor's Office thereafter. The primary goal is the reduction of infant mortality to no more than nine infant deaths per 1000 live births by 1990.

- **The Governor's Office should consider working with the Hospital Association and State Department of Health in actively developing hospital discharge summary reporting for birth defects.** This information should be compiled and made available to the State Department of Health to develop a birth defects registry. This registry should then be used for the identification and follow-up of infants with birth defects who need special services.

Recommendations: Provider Education



The Task Force acknowledges delivery of adequate perinatal care requires public awareness of the need for such care and appropriate guidelines for providers giving care. Physicians, nursing staff, and others who are responsible for providing such care should do so with the most up-to-date skills available. The following recommendations are therefore made:

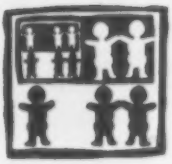
- **The Governor's Office and the Legislature should support one central source for perinatal education through the University of Mississippi Medical Center. Approval of any state or federal dollars statewide for perinatal education should stipulate coordination with University Medical Center and use of this common curriculum or protocol.** The University Medical Center Departments of Obstetrics and Pediatrics should work in cooperation with the Governor's Office, the State Department of Health, and Level II and Level I hospitals for implementation of a perinatal outreach education curriculum for all obstetrical and neonatal providers statewide. The University Medical Center has a Federal Maternal and Child Health grant which will expire September 30, 1987, and state funding should be available to continue this education project after termination of the grant. This education would provide a perinatal curriculum including care of low risk and high risk mothers and infants. Evaluation methodologies would be built into the curriculum to evaluate the effectiveness of the perinatal education for content, organization, presentation, and impact upon clinical practice.

- **The Governor's Office should support the implementation of statewide perinatal education by utilizing coordinators and instructors from University Medical Center who would provide training, monitoring, materials, and resources to regional perinatal specialists in Level II facilities statewide. The regional perinatal specialists would teach providers and promote implementation of current standards of practice.** This education would be available in Level I and Level II hospitals, birthing centers, and ambulatory clinics, with basic funding provided by state dollars and fees.

- **The Governor's Office should support malpractice carriers in making coverage of perinatal care contingent on providers' participating in at least a minimum number of approved hours of perinatal education per year.** A discount should be considered for malpractice premiums as an additional incentive to encourage provider participation. The setting of required hours should be done by the insurance carriers with consultation with appropriate groups such as the Mississippi Obstetrics and Gynecology Society, the Mississippi Chapter of the American Academy of Pediatrics, the Mississippi Academy of Family Physicians, and the Mississippi Nurses Association.

- **The Governor's Office should support the necessary funding for implementation of the nurse-midwifery education program authorized by the Mississippi Legislature in 1985.** This would provide the personnel for cost-effective family-centered care for low risk maternity patients close to home.

Recommendations: Finance and Access



Although the state may in good conscience develop appropriate standards, adequate public awareness, and proficient expertise on the part of providers in dealing with perinatal problems, the problem of access will remain unless adequately dealt with. The cost of perinatal care is borne now by several sources, including tax revenues, county funds, and insurance. This cost of care, whether planned or unplanned, is always borne by the public although not necessarily in a visible way. This Task Force recommends a more organized and planned utilization and distribution of resources to assure a system of appropriate care. This would result, over the long term, in improved outcomes for Mississippi's mothers and children. The following recommendations are therefore made.

Medical Malpractice Insurance

- **The Task Force recommends that the 1986 Senate and House consider and pass legislation which would limit the awarding of monetary damages through a cap on "pain and suffering judgements" and the elimination of the collateral resource rule** (ability to introduce other financial help received for the alleged condition). The excessive cost and availability of medical malpractice insurance is becoming an increasing factor in the diminishing participation of perinatal providers nationwide. A number of states have recently made attempts to alleviate the crisis and slow the rate of increase of malpractice cost. California has enacted legislation in this area which has been upheld by the United States Supreme Court.

- **The Task Force also recommends that sovereign immunity for the University Hospital be repealed immediately to more equitably share medical malpractice risks and insurance costs between the University Medical Center and its health care providers inasmuch as they together provide care for a predominantly high risk (medically and medicolegally) population of pregnant patients.**

Medicaid

- **The current Medicaid eligibility standards provide coverage only of families at about 35 percent of the federal poverty level. This is felt to be woefully inadequate and should be raised by the Welfare Board, supported with adequate appropriations from the Legislature, and maintained at a level at least equal to if not more than 50 percent of the federal poverty level.** This standard of need should be adjusted yearly. Medicaid is the major financial source of payment for perinatal care to low-income patients in Mississippi.

- Therefore, **the Task Force recommends that the State Medicaid Division increase office fees to pediatricians and family practitioners for child health care to a level of somewhere between $25 and $30 to encourage participation of these physicians in Medicaid.** Although many infants are born healthy and of normal birthweight, they die before their first birthday because of failure to access acute care when ill. A recent survey by the Mississippi Academy of Pediatrics shows that this level of reimbursement would result in a marked increase in participation by private providers in the provision of acute pediatric care.

- **The Governor's Office should support the continued statewide outreach through public information to families potentially eligible for Medicaid.** This should include the provision and funding of a statewide telephone hotline to be used to report perinatal access problems for both Medicaid and poor patients not eligible for Medicaid.

- **The Governor's Office should support an increase in both the number of physician office visits and the number of hospital days allowed by Medicaid to assure appropriate comprehensive perinatal care for mothers and children. There should also be an increase in the number of in-patient hospital days allowed for neonatal care and care of sick infants in the first month of life to assure appropriate care for high risk neonates.**

- **To assure that infants receive the most appropriate comprehensive care possible, the Task Force recommends to the Governor's Office that Medicaid approve only providers of EPSDT who provide a broader and more comprehensive infant and child health service than just health screening.**

Uncompensated Care

The Governor's Office is asked to coordinate with the Legislative Committee on Uncompensated Care to recommend to the Legislature by FY 1987 a proposal to address uncompensated care for perinatal services in this state. This recommendation should address not only in-patient hospital care but also should look at potential solutions to pay for uncompensated physician care and ambulatory care. This proposal should also include specific cost containment stipulations while maintaining quality of services. A number of states including Florida, South Carolina, Georgia, Arkansas, and Texas have recently passed bills which impact on uncompensated care and should be reviewed for potential application to Mississippi.

- **The Governor's Office should support and encourage a plan that would immediately give special attention to assuring planned access for hospital delivery for all women based on risk as well as acute and well-child care in the first year of life.**

- **The Governor's Office should support and recommend to the Legislature increased state funds for the Mississippi State Department of Health's High Risk Maternity Program to assure appropriate care for all high risk women at or below poverty level income who are not eligible for Medicaid.** Additional funds should also be appropriated for low risk poor women not eligible for Medicaid to assure access for a planned delivery in a hospital or approved birthing center.

- **The Governor's office should support legislation that would require employers of two or more employees, whose income must be reported to the IRS, to make available health insurance benefit plans for the employees and dependents.** The employer must pay a minimum of 50% of insurance cost of the plan to assure that employees will be able to take advantage of the plan.

Maternal and Infant Transport

A formal system for maternal transport does not currently exist in the state and is essential to appropriate and early intervention in emergency perinatal situations.

- **The Governor's Office should support a transport system that would be implemented and coordinated through the existing Office of Emergency Medical Services of the State Department of Health and the University of Mississippi Medical Center.** Funding should be made available through the Legislature to allow for training emergency personnel and needed equipment.
- **The funding of the Newborn Transport System should be transferred from the State Department of Health to the University of Mississippi Medical Center since the University Medical Center is currently operating the Newborn Transport System.** This appropriation is currently $138,000 and has not been increased in the last five years. It is recommended that the Legislature increase funding to at least $200,000 and reassess annually to cover the actual costs of providing appropriate transport.

University of Mississippi Medical Center

- **The Governor's Office should support, as a high priority, funding for expansion of in-patient perinatal services for the University Medical Center by the Board of Trustees of Institutions of Higher Learning.** This recommendation should be viewed in light of the currently projected number of deliveries at the University Medical Center and the statewide perinatal services provided. In conjunction with this, the Governor's Office should work with the State Department of Health, University Medical Center, primary care (330) projects, and other agencies in the greater Jackson area to develop delivery access in area hospitals other than University Medical Center. This should help reduce the delivery load at the Medical Center and allow for appropriate perinatal expansion to be made. This should include an evaluation of low risk deliveries occurring in the central part of the state with the goal of developing alternate delivery plans for these low-risk patients outside the University of Mississippi Medical Center.

- **A sliding fee scale for physician and inpatient care charges should be initiated at the state-supported acute care hospitals.** Patients below the federal poverty level should not be charged, or current charges should be at a reduced level. For patients at or below the poverty level, no delivery deposit or "up front" money should be required for delivery. A sliding fee scale should be implemented for patients above the poverty level for all pediatric and maternity outpatient care.

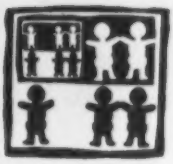
The State Department of Health should contact all hospital emergency rooms and request reporting to the county health department of any patients presenting for delivery who were not followed by a health provider for prenatal care. This would include any patients who have either failed to receive adequate prenatal care or simply "dropped in" to deliver. This information should then be used to insure these families are offered access to postpartum, family planning, and pediatric services.

Legislative support should be provided to the State Medical Examiner to require autopsies of all infants (0-24 months) who die suddenly from unexplained causes. Additional Legislation should be passed which states that only those deaths for which there has been an autopsy should be labeled Sudden Infant Death Syndrome.

Special Studies

The Governor's Office should convene a group consisting of individuals from the obstetric and pediatric departments from the University Medical Center, the State Department of Health, the March of Dimes, and other interested groups to recommend interventions for the prevention of low-birthweight in Mississippi. Since the excessive number of small babies born correlates strongly with our high infant mortality rate, special emphasis needs to be taken to address this problem. These recommendations should be submitted to the Governor's Office by October 1986.

Summary



The above recommendations, although not totally inclusive, do detail a number of actions or steps that should be taken by various entities to deal with our excessive infant death rate. Many of these steps do not require additional money but only adequate coordination and commitment on the part of various groups. Some recommendations, if adopted, will require an increased degree of coordination and financial commitment to improve perinatal care that has heretofore not existed in this state. The Infant Mortality Task Force recommends to the Comission for Children and Youth and the Governor that this report be adopted and implemented. The Task Force is available for further detailing of specific recommendations or for assistance in individual issues regarding implementation.

Infant Mortality Task Force Members

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Mississippi State Department of Health
Chairman, Infant Mortality Task Force

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Jackson

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Pediatrician
Brookhaven

Mrs. Barbara Brunini
Junior League of Jackson
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Blue Cross/Blue Shield
Jackson

Ms. Beverly Courtney
Head Start
Greenville

Ms. Sandi Dietrich
Mississippi Chapter, ACNM
Madison

Mrs. Joyce Dortch
Citizen
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The Honorable Isiah Fredricks
Mississippi House of Representatives
Gulfport

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Citizen
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Ms. Marilyn Williams
Mississippi Hospital Association
Jackson

INFANT MORTALITY RATE REDUCTION

1986

Infant Mortality Rates

	Total	White	Nonwhite
South Carolina	13.2	10.2	17.9
Alabama (prov)	13.2	9.6	19.7
Mississippi	12.3	8.9	16.2
	Neonatal Mortality Rates		
South Carolina	8.8	6.9	11.7
Alabama	9.0	6.8	13.0
Mississippi	7.7	6.0	9.6
	Postneonatal Mortality Rates		
South Carolina	4.4	3.3	6.2
Alabama	4.2	2.9	6.6
Mississippi	4.6	2.9	6.6

	1984	1985	1986
Infant Mortality			
South Carolina	14.7	14.2	13.2
Alabama	12.9	12.6	13.2
Mississippi	14.8	13.7	12.3

Other states surveyed:
Georgia - very provisional 12.1 IMR 8.2 NMR 3.9 PNMR
Tennessee - no rate
Louisiana - no rate

OCT 5 1987

STATE OF MISSISSIPPI
GOVERNOR'S OFFICE OF FEDERAL-STATE PROGRAMS

ROY THIGPEN
Executive Director
Federal-State Programs

September 28, 1987

WILLIAM B. CHISM
Interim Director
Department of Human Development

Congressman Mickey Leland
United States House of Representatives
Chairman, House Select Committee on Hunger
Room H-2507 House Office Building Annex 2
Washington, D.C. 20515

Dear Congressman Leland:

Please find attached information answering the questions you posed in your followup letter. I hope this is helpful. Mr. Royal Walker has been appointed the new director of Human Development and can further assist you.

Sincerely,

William B. Chism

WBC:lg

Attachments

MISSISSIPPI
STATE DEPARTMENT OF
HEALTH

Reply To:

Alton B. Cobb, M.D., M.P.H.
State Health Officer

P.O. Box 1700 2423 North State Street Jackson, Mississippi 39215-1700 (601) 960-7400

September 8, 1987

Mr. William B. Chism, Interim Director
Department of Human Development
Governor's Office of Federal-State Programs
301 West Pearl Street
Jackson, MS 39203-3090

Dear Mr. Chism,

Pursuant to your request regarding the questions from the House Select Committee on Hunger, I will explain how the State Department of Health assists in informing low-income persons about their possible eligibility for participation in public assistance programs.

The county health departments employ a limited number of social service workers who assist clients in accessing needed social services. When a patient is referred to one of the social service workers, all of the patient's needs are considered, and the worker tries to direct the patient to the appropriate agencies and assist him/her in making application for services.

In addition, this agency has actively participated in information campaigns regarding the availability of new programs, such as expansions in Medicaid, through the distribution of posters and pamphlets in an effort to inform persons who might be eligible. The Supplemental Food Program for Women, Infants, and Children (WIC) serves women and children with incomes up to 185 percent of the poverty level. Regulations for this program require staff to inform clients about public assistance programs such as AFDC.

I hope this information will be helpful in your response to the Committee. Should you need clarification or additional information, please advise.

Sincerely,

Alton B. Cobb, M.D., M.P.H.
State Health Officer

ABC/TH/kc

RECEIVED
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DEPT. OF HUMAN DEVELOPMENT

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To assure adequate outreach, the staff of the Office of Energy and Community Services and the LIHEAP staff at the local agencies will contact the statewide network of agencies and organizations that deal with potentially eligible households. These agencies and organizations include, but are not limited to: the state and local Departments of Public Welfare, Mississippi's Planning and Development Districts, the Mississippi Council on Aging and the state's 10 Area Agencies on Aging, the Mississippi Municipal Association, state and local vocational rehabilitation offices, district and branch offices of the Social Security Administration and regional offices of the Veterans Administration. Further, the Office of Energy and Community Services will use newspaper coverage, flyers and posters, and public service announcements on radio and television, to inform individuals of their potential eligibility. Specific outreach assistance for the LIHEAP operation has been offered by the Mississippi Council on Aging, Office of Handicapped Services, and the Office of Voluntary Citizen Participation, as well as the Commission for Children and Youth. These groups, in addition to local staff, will work with their local networks to identify and serve those most needy households. It should be noted here that local community action agencies and other community-based organizations will rely upon their existing networks of volunteers, community leaders, church groups, etc., to provide outreach aimed at targeting services to those eligible households with the greatest need for energy assistance. It should also be noted that the Office of Energy and Community Services has met with representatives of the state energy vendors, and their input and cooperation has been solicited in rendering assistance to needy families. Advertisements will emphasize elderly individuals and handicapped individuals and program efforts will place a priority effort on serving these two particular groups. A three-week closed application period at the beginning of the program will be provided for elderly and handicapped applicants. Home visits will be made to homebound applicants.

D. Coordinate its activities under this title with similar and related programs administered by the Federal Government and the State of Mississippi, particularly low-income energy-related programs under Sub-Title B of Title VI (related to the Community Services Block Grant Program), under the supplemental income program, under Part A of Title IV of the Social Security Act, under Title XX of the Social Security Act, under the low-income weatherization assistance program under Title IV of the Energy Conservation and Production Act, or under any other provision of law which carries out programs which were administered under the Economic Opportunity Act of 1964 before the date of the enactment of this Act.

The Office of Energy and Community Services will coordinate its activities for this program with similar and related programs administered by the federal government and/or state government; particularly programs administered by the community action agencies, the Social Security Administration, and the Department of Energy funded low-income weatherization assistance program. A referral mechanism will be set up to refer to, and receive referrals from, these programs.

E. Provide, in a manner consistent with the effective and timely payment of benefits, that the highest level of assistance will be furnished to those households which have the lowest incomes and the highest energy costs in relation to income, taking into account family size, except that the State will not differentiate in implementing this section between the households described in clause 2605(b)(2)(A) and (b)(2)(B).

A payment chart will be used which insures that the highest level of assistance is furnished to those households which have the lowest incomes and the highest energy cost in relation to income, adjusted to family size. Eligible households will receive assistance only once during a fiscal year. The only exception to this is in the case of a life threatening emergency or presidentially or gubernatorially declared disaster. In that event, a household may receive one payment through the regular energy program and another through the Emergency Crisis Intervention Program. No difference in the application process, determination of eligibility, or amount of payment will be made based upon types of income received by household members. The State will not differentiate in implementing this section between the households described in clause (2)(A) and (2)(B) of this subsection.

F. In designating local administrative agencies to carry out the purposes of this Title, give special consideration to any local, public or private nonprofit agency which was receiving federal funds under any low-income energy assistance program or weatherization program under the Economic Opportunity Act of 1964 or any other provision of law on the day before the date of the enactment of this Act, except that

1. the State of Mississippi shall, before giving such special consideration, determine that the agency involved meets program and fiscal requirements established by the State of Mississippi, and

2. if there is no such agency because of any change in the assistance furnished to programs for economically disadvantaged persons, then the State of Mississippi shall give special consideration in the designation of non-profit local administering agencies to any successor agency which is operated in substantially the same manner as the predecessor agency which did receive funds for the fiscal year preceding the fiscal year for which the determination is made.

This plan calls for the use of the already existing community action agency network in the state, where possible. These agencies are already in place, have service delivery systems in place, and have the local contacts that are necessary in order to carry out a program of this magnitude. The use of these existing agencies, or any other agency, depends on that agency meeting the program and fiscal requirements necessary to carry out this program. If these agencies are unable to fulfill the requirements of the program, for whatever reason, then special consideration will be given to utilizing other community-based type organizations. The primary criteria in choosing agencies to carry out the program will be past performance of the agency involved, present delivery mechanisms of the agency, overall capability to service the given area in a timely and effective manner, and a

service the given area in a timely and effective manner, and a satisfactory assessment by the Office of Energy and Community Services and/or the Department of Audit and Evaluation.

G. Establish procedures for those home energy suppliers which are paid directly to assure that the State will:

1. notify each participating household of the amount of assistance paid on its behalf;

2. assure that the home energy supplier will charge the eligible household, in the normal billing process, the difference between the actual cost of the home energy and the amount of the payment made by the State of Mississippi under this Title;

3. assure that the home energy supplier will provide assurances that any agreement entered into with a home energy supplier under this paragraph will contain provisions to assure that no household receiving assistance will be treated adversely because of such assistance under applicable provisions of state law or public regulatory requirements; and

4. assure that any home energy supplier receiving payments agrees not to discriminate, either in the cost of the goods supplied or the services provided, against the eligible household in whose behalf payments are made.

Mississippi will sign agreements with the larger home energy suppliers so that some recipients will receive benefits which are paid on their behalf to the home energy supplier. The local service delivery agencies will be responsible for taking applications and certifying eligibility based on guidelines provided by the State Agency. The State Agency will be responsible for allocating funds to local agencies and will disburse these funds based on request for payment procedures. Energy payments that are made to vendors not participating in the direct payment program will be made in the form of a co-payee check listing the vendors name and the applicant's name on the payee line. Each check will be stamped in red with the words "CASH BY ENERGY VENDOR ONLY" and will have a caveat on the endorsement which says "BY SIGNING THIS CHECK, I ASSURE THAT THE MONIES RECEIVED WILL BE APPLIED TO THE COST OF HOME ENERGY."

In participating in the system, all home energy suppliers will be agreeing to:

a) charge the eligible household, in the normal billing process, the difference between the actual cost of the home energy and the amount of payment made by the state under this title;

b) assure that no household receiving assistance will be treated adversely because of such assistance, under applicable provisions of state law or public regulatory requirements; and

c) agree not to discriminate, either in the cost of the goods supplied, or services provided, against the eligible household on whose behalf payments are made.

The State agrees to notify each participating household of the amount of assistance.

These procedures will apply to all aspects of program operation including the regular heating and cooling components of the program as well as the Emergency Crisis Intervention and Weatherization components of the program.

H. Provide assurances that the State of Mississippi will not exclude households with incomes which do not exceed the greater of an amount equal to 150 percent of the poverty level for the State or an amount equal to 60 percent of the State Median Income. It is further assured that no household will be excluded which has an income equal to or less than 110 percent of the poverty level of the State and the State will treat owners and renters equitably.

The eligibility criteria for income will be 130 percent of the poverty level determined by the Office of Management and Budget. This will be the only income criteria. Eligibility and the amount of assistance will be determined in the same manner for all applicants regardless of source of income or living arrangments, including owners and renters. These procedures will apply to all aspects of program operation including the regular heating and cooling components of the program as well as the Emergency Crisis Intervention and Weatherization components of the program.

I. Not use an amount exceeding ten percent (10%) of its allotment each fiscal year for planning and administering the use of funds under this Title for the fiscal year and not transferred pursuant to Section 2604(f), and the State will pay from non-federal sources the remaining costs of planning and administering the program administered under this Title and no federal funds will be used for such remaining costs.

For Fiscal Year 1988, the State agrees not to exceed 10% of its allotment for planning and administering the use of the funds under this Title. No part of the allocation will be transferred to other block grants.

J. Establish and provide such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursal of and accounting for Federal funds paid to the State under this Title, including procedures for monitoring the assistance provided, and at least every two years the State shall prepare an audit of its expenditures of amounts received and amounts transferred to carry out the purpose of the Title.

In order to assure that proper fiscal control and fund accounting procedures are followed in the carrying out of this program, the following general mechanisms will be used:

1. Federal funds will only be drawn down on an as-needed basis, in order to carry out current obligations. Funds will only be dispensed to the local agencies based on projected local agency needs on a semi-monthly basis, in the case of direct assistance to eligible households and in the case of administrative funds necessary to carry out the program at the local level. In both cases, overall contractual allocations would regulate maximum expenditures.

2. A monitoring system involving periodic visits, both scheduled and unscheduled, to participating agencies in order to determine programmatic and fiscal compliance, as well as to provide technical assistance is in place.

3. A compliance and financial audit will be budgeted for, and carried out annually, under the provisions of this Title by an organization or person independent of any agency administering activities under this Title. The audit shall be conducted in accordance with the Comptroller General's standards for auditing governmental organizations, programs, activities and functions. This audit will be made available to the State Legislature and to the Secretary of Health and Human Services through the Governor of the State of Mississippi within 30 days after the completion of the audit.

K. Permit and cooperate with federal investigations undertaken in accordance with Section 2608 of the Title to which this application relates.

The State agrees to fully cooperate with any investigation arising from complaints concerned with the use of funds, as provided under the Title. Further, it is understood that an on-going program of investigations shall be conducted within several States each year by the Federal Government, in order to evaluate compliance with the provisions of the Title, and that the Comptroller General will evaluate each program at least every three years. The Office of Energy and Community Services stands ready to fully cooperate with any investigation undertaken.

L. Provide for public participation in the development of the plan and any substantial revision of the plan as described in Subsection (c). Additionally, as required by regulations, the state will conduct public hearings with respect to the proposed use and distribution of funds to be provided under this Title.

The State of Mississippi will comply with this requirement through a public hearing to be held in Jackson on June 25, 1987. This hearing will provide an opportunity for public comment, discussion, and suggestions concerning the use and distribution of funds.

Further, the Mississippi LIHEAP public participation plan calls for informing the general public about the existence of the program by publishing a summary of major provisions of the plan, including any waiver requirements, in local newspapers throughout the state. All of the media, including newspapers, television, and radio are routinely given information concerning the program, including how

the public can participate in the plan review and comment process. The public is also informed of the availability of LIHEAP through the 84 local Department of Public Welfare offices, 19 Community Action Agencies, and the 10 Planning and Development Districts of the state. The proposed State Plan is placed for inspection at the local Department of Public Welfare offices (DPW), Community Action Agency offices, and in each county courthouse. Plans are also provided to each Area Agency on Aging, Vocational Rehabilitation Division of the State Department of Education, the Office of Vocational Rehabilitation for the Blind, and members of the LIHEAP Advisory Committee. The State Application (Plan) will be available to the general public by June 1, 1987, and a period of 20 days will be allowed for comments, allowing the general public to express their needs, identify specific priorities and make recommendations regarding the allocation of resources as specified in the State Plan. At the end of the public hearings and review period, the input received as a result of the public participation process will be incorporated prior to submission to the Secretary of Health and Human Services. Substantial revisions to the plan during the fiscal year will be handled in the same manner as the original plan, with respect to public comment.

M. Provide an opportunity for a fair administrative hearing to individuals whose claims for assistance under the plan described in Subsection (c) are denied or are not acted upon with reasonable promptness.

A fair administrative hearing process has been set up, whereby individuals whose claim for assistance is denied, or is not acted upon with reasonable promptness, may request a determination in order to ascertain whether their case was handled fairly. This process will begin at the local level and will terminate with a formal hearing, if the complaint cannot be resolved prior to that level. An applicant will have 30 days, following the notification of denial, in which to make a written request for a hearing. These procedures will apply to all aspects of program operation including the regular heating and cooling components of the program as well as the Emergency Crisis Intervention and Weatherization components of the program.

N. Identify households as eligible to participate under this Title through the following procedures:

Applications for assistance under this Title will be made on a first-come, first served basis, with a closed application period during the first three weeks of program operation for elderly and handicapped. In order to participate in the program, applicants must provide proof of energy responsibility and either proof of income for all household members or proof that the household is currently eligible for and receiving food stamp benefits.

Benefit levels for eligible households are determined by the gross annual income for the household, the number of persons in the household, the type of fuel used as the primary source, and the heat-degree section of the state in which the household resides. A payment chart is shown in Section XI of this application.

O. Set aside from funds available to this State a reasonable amount based on data from prior years for Energy Crisis Intervention. Of the total allocation given this State, three percent is set aside for the Energy Crisis Intervention Program for the entire fiscal year. Based on prior years' data, .05 percent of the total allocation will be set aside for Energy Crisis Intervention until March 15 and will be used between March 15 and September 30.

Energy Crisis is defined as weather-related and supply shortage emergencies and other household energy-related emergencies. Applicants must meet the income and energy responsibility eligibility criteria, and must also be experiencing a verifiable energy crisis, e.g., cut-off notice from energy vendor, household member in life-threatening situation because of need for utilities, or household directly affected by gubernatorially or presidentially declared disaster.

The payments through the Emergency Crisis Intervention Program (ECIP) will be handled, i.e.:

1. Assistance must be provided within 48 hours after a household applies if the household is eligible for energy crisis benefits;

2. Assistance must be provided within 18 hours after a household applies if a life-threatening situation exists and the household is eligible for energy crisis benefits; and

3. Each entity that administers an ECIP must:

   a) accept applications at sites that are geographically accessible to all households in the area served by the entity; and

   b) provide low-income individuals who are physically infirm with the means to submit applications for energy crisis benefits without leaving their residences or the means to travel to sites at which applications are accepted.

Eligibility for these funds will be the same as for regular program assistance, i.e., the household's verified gross annual income must be equal to or less than 130% of the OMB poverty guidelines and the household must provide documentation of energy responsibility. The only additional eligibility criterion is that the household must be experiencing a verifiable weather related, supply shortage or other household related emergency. Eligibility will be determined by the same subcontractor agencies that operate the regular program.

In the unlikely event that the funds reserved under this Section for the purposes of this Title are not expended for emergencies, these funds will be transferred to regular program assistance (energy bill, heating and/or cooling equipment, and other energy related repairs/maintenance) and will be used for payments to eligible households.

P. Provide the Department of Health and Human Services with a description of energy usage and the average cost of home energy, by fuel type and region. A chart is attached to this application which contains this information (see page 12). The data on this chart is the result of a survey conducted of energy vendors in the State of Mississippi.

Q. Cooperate with the Department of Health and Human Services in the collection and reporting of pertinent data with respect to all facets of the Low Income Home Energy Assistance Program. A management information system is in place at the state level to generate demographic information.

R. Provide for options within the Title.

The State offers the following comments concerning these options:

In reference to Section 2604 of the Title, Indian tribes have the option of applying directly to the Secretary of Health and Human Services for their pro rata share of the state's allotment. The State is aware of the intent of the Choctaw Nation to apply for and receive their funds directly.

The State realizes the option to transfer up to ten percent (10%) of the allocation to other specified programs, but feels that this option should not be exercised at this point.

The state may choose the option of placing fifteen percent (15%) of the Low Income Home Energy Assistance Funds into weatherization activities.

III. Compliance with Assurances

A description of the methods Mississippi will use to carry out each of the seventeen (17) assurances is contained in Section II, Assurances of this application.

IV. Use of Funds

Estimates of funds to be used for each program under the Plan are shown by chart on page 10, Item VII.

V. Eligibility Requirements by Type of Assistance

A. LIHEAP - Regular Assistance

1. Household's verified gross annual income must be equal to or less than 130% of the OMB poverty guidelines; and

2. Household member must provide documentation that establishes energy responsibility.

B. LIHEAP - Energy Crisis Intervention Program (ECIP)

1. Household's verified gross annual income must be equal or less than 130% of the OMB poverty guidelines;

2. Household member must provide documentation that establishes energy responsibility; and

3. The household must be experiencing a verifiable weather related, supply shortage, or other household related emergency.

C. Weatherization Assistance Program

1. Household's verified gross annual income must be equal to or less than 130% of the OMB poverty guidelines; and

2. Household must reside in a dwelling unit that will produce an energy savings as as result of weatherization efforts.

VI. Weatherization Assistance Program

The Weatherization Assistance Program, administered by the Office of Energy and Community Services, may receive fifteen percent (15%) of the LIHEAP allocation made to the State of Mississippi. No vulnerable Mississippi resident will be excluded from service, but priority will be given to the elderly and handicapped. Assistance will be furnished to low income households, with consideration given to the condition of the dwelling and its potential for energy savings. The regulatory requirements of the United State Department of Energy will apply to all areas of the Weatherization Assistance Program and the energy related and home repairs necessary to protect or supplement the weatherization measures made through this program.

The total per unit cost including program support, materials, and minor repairs will average no more than $1,600.

VII. Budget

The State of Mississippi plans to allocate funds received in the following manner:

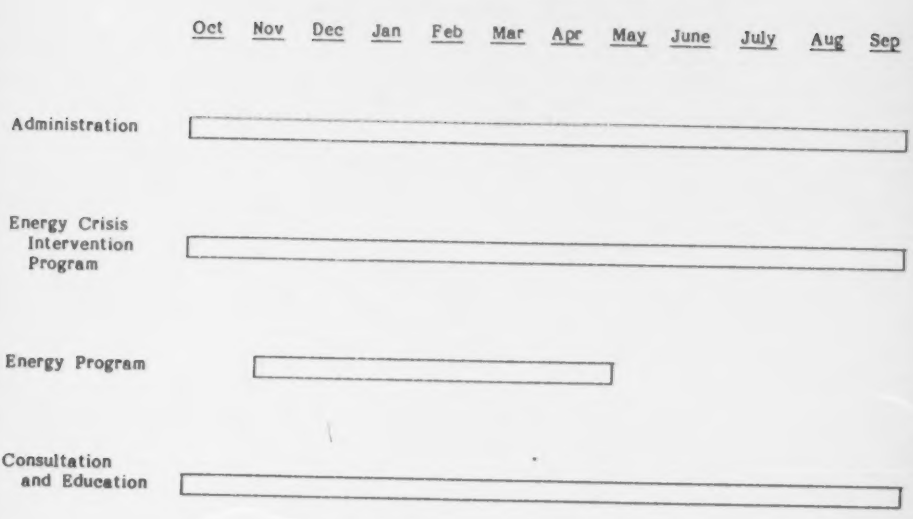
Administration		10%
Weatherization		15%
Energy Programs		72%
Energy Crisis Intervention		3%
	Total	100%

78-070 O - 88 - 7

VIII.

Fiscal Year 1988

Timeline for Energy Assistance Programs



IX.

FUEL USE

	Percent of Use	Average Yearly Use	Average Yearly Cost
Natural Gas			
Region I	41.38	65.1 MCF[1]	$328
Region II	40.77	79.1 MCF	$397
Region III	41.93	79.4 MCF	$398
Region IV	30.08	80.3 MCF	$402
Electricity			
Region I	35.10	11,832 KWH[2]	$593
Region II	14.94	9,696 KWH	$596
Region III	14.54	9,792 KWH	$609
Region IV	24.98	11,124 KWH	$552
Liquid Petroleum Gas			
Region I	23.28	420 G[3]	$376
Region II	43.55	451 G	$435
Region III	41.77	512 G	$629
Region IV	40.58	655 G	$520
Wood			
Region I	.16	2.5 C[4]	$225
Region II	.68	3 C	$225
Region III	1.43	3.5 C	$297
Region IV	4.32	4.5 C	$270
All Other			
Region I	.08		
Region II	.06		
Region III	.38		
Region IV	.04		

1 Hundred Cubic Feet
2 Kilowatt Hours
3 Gallons
4 Cords

REGION IV
REGION III
REGION II
REGION I
ARKANSAS
LOUISIANA
LOUISIANA
ALABAMA
- 13 -

XI.

PAYMENT CHART

Number in Household	Category I	Category II	Category III
1	7,150	5,500	4,125
2	9,620	7,400	5,550
3	12,090	9,300	6,975
4	14,560	11,200	8,400
5	17,030	13,100	9,825
6	19,500	15,000	11,250
7	21,970	16,900	12,675
8	24,440	18,800	14,100
9	26,910	20,700	15,525
10 (and over)	29,380	22,600	16,950

	Category I				Category II				Category III			
Region I	Wood	NG	LPG	Elec	Wood	NG	LPG	Elec	Wood	NG	LPG	Elec
	80	90	100	110	90	100	110	120	100	110	120	130
Region II	Wood	NG	LPG	Elec	Wood	NG	LPG	Elec	Wood	NG	LPG	Elec
	90	100	110	120	100	110	120	130	110	120	130	140
Region III	Wood	NG	LPG	Elec	Wood	NG	LPG	Elec	Wood	NG	LPG	Elec
	100	110	120	130	110	120	130	140	120	130	140	150
Region IV	Wood	NG	LPG	Elec	Wood	NG	LPG	Elec	Wood	NG	LPG	Elec
	110	120	130	140	120	130	140	150	130	140	150	160

MEMORANDUM

To : Brad Chism
Deputy Director
Federal-State Programs

From : Joy Tharp
Interim Director, Department of Job Development and Training

Date : August 31, 1987

Subject: Follow-Up Questions by Select Committee on Hunger

In response to your request, we are providing answers to the two questions which relate to JTPA. Please contact me if you need any additional information.

Question

What methods are used to inform low-income persons about their possible eligibility for participation in public assistance programs?

Answer

Potential clients are recruited through a variety of methods. Major sources of clients are other service agencies; i.e., Mississippi Employment Security Commission, Department of Public Welfare, Department of Rehabilitation Services, schools, etc. Other clients are recruited through media announcements and outreach efforts.

Question

How effectively is JTPA matching its job training activities with local employment possibilities?

Answer

JTPA dollars can only fund training programs in demand occupations. Prior to selecting a program for funding, placement potential is carefully analyzed. Since all Service Delivery Areas exceeded their placement standard in Program Year 1986, we feel the matching of job training activities with local employment possibilities has been effective.

JT:drb

11t 1

PREPARED STATEMENT OF LOUIS E. ARMSTRONG, DIRECTOR,
MISSISSIPPI LEGAL SERVICES COALITION

I APPRECIATE THE OPPORTUNITY TO PRESENT THE VIEWS OF THE LEGAL SERVICES COMMUNITY IN MISSISSIPPI REGARDING THE PROBLEMS OF THE POOR. THE SIX LEGAL SERVICES CORPORATIONS IN MISSISSIPPI PROVIDES LEGAL REPRESENTATION TO AN ELIGIBLE POPULATION OF 587,000 POOR MISSISSIPPIANS. MANY TIMES THE LEGAL SERVICES OFFICE IS THE LAST RESORT FOR CLIENTS WHO OTHERWISE HAVE NO RECOURSE AS A RESULT OF DECISIONS MADE BY BUREAUCRATS WHICH VIOLATE FEDERAL AND STATE MANDATES OF LEGISLATIVE BODIES.

IN JUNE, 1984, THIS COMMITTEE VISITED THIS PLACE TO ACCESS THE EFFECTIVENESS AND ACCESSIBILITY OF FEDERAL FOOD ASSISTANCE PROGRAMS IN RURAL MISSISSIPPI AREAS. AFTER MORE THAN THREE (3) YEARS THE SITUATION HAVE GOTTEN WORSE. CONTINUING FEDERAL REDUCTIONS AND THE LACK OF AVAILABLE STATE FUNDS HAVE PRODUCED A SITUATION IN MISSISSIPPI WHERE THOUSANDS OF CHILDREN GO TO BED HUNGRY EACH NIGHT; A SITUATION WHERE HUNDREDS OF OUR ELDERLY SUFFER NEEDLESS PAIN AND EVEN DEATH BECAUSE OF THE LACK OF ADEQUATE MEDICAL CARE, WHERE THOUSADS OF MEDICAID MOTHERS HAVE TO MAKE THE DECISION BETWEEN FOOD AND SHELTER OR FOOD AND HEAT.

SPECIFICALLY, THE MOST SERIOUS PROBLEM RELATED TO FOOD STAMP PARTICIPATION IN MISSISSIPPI IS THE SHEAR LACK OF ADEQUATE STAFF TO

PROVIDE SERVICES TO THOUSANDS OF ELIGIBLE CLIENTS LOCATED THROUGHOUT RURAL AND URBAN MISSISSIPPI. FEDERAL LAW MANDATES THAT WITHIN THIRTY (30) DAYS AFTER INITIAL APPLICATION A FOOD STAMP APPLICANT SHOULD HAVE FOOD STAMPS IN HAND. IN MISSISSIPPI THIS IS CERTAINLY NOT THE CASE. THE MOST FREQUENT COMPLAINT WE HEAR IN THE LOCAL LEGAL SERVICES OFFICE REGARDING FOOD STAMP PARTICIPATION IS THE TIME IT TAKES FOR RECIPIENTS TO RECEIVE FOOD STAMPS AFTER THE INITIAL APPLICATION. THAT TIME PERIOD REACHES FAR BEYOND THE THIRTY (30) DAY LIMIT REQUIRED BY FEDERAL LEGISLATION. ADDITIONALLY, FOOD STAMP CLIENTS ARE NOT NOTIFIED WHEN CHANGES ARE MADE IN ELIGIBILITY. FOR INSTANCE, RECENTLY A CLIENT WAS TERMINATED FROM THE FOOD STAMP PROGRAM DUE TO AN INCREASE IN INCOME WHICH WAS REPORTED TO THE LOCAL OFFICE. THE CLIENT WAS NEVER NOTIFIED THAT SHE HAD BEEN TERMINATED UNTIL SHE ARRIVED AT THE WELFARE DEPARTMENT TO COLLECT HER FOOD STAMPS. HAD SHE NOT BEEN PREPARED FOR SUCH A HARDSHIP SO THIS FAMILY WENT TO BED HUNGRY THAN MORE THAN A FEW NIGHTS THAT MONTH.

THERE IS A SERIOUS PROBLEM WITH THE FLOW OF INFORMATION BETWEEN THE CLIENTS AND THE WELFARE DEPARTMENT. AGAIN, THIS IS THE RESULT OF A SEVERELY UNDERSTAFFED PUBLIC BENEFITS SYSTEM DUE TO THE LACK OF ADEQUATE FUNDING BY THE STATE LEGISLATURE. CONGRESS SHOULD REQUIRE THAT STATES WHO PARTICIPATE IN THESE PROGRAMS MAINTAIN A BETTER STAFF FOR POOR PERSONS RATIO.

THE AID TO FAMILY WITH DEPENDENT CHILDREN OR AFDC PROGRAMS IN MISSISSIPPI IS ONE OF THE LOWEST IN THE UNITED STATES OF AMERICA. THE MAXIMUM AFDC PAYMENTS IN MISSISSIPPI IS $144 PER MONTH. MANY TIMES THE COST OF UTILITIES EXCEEDS THIS MEAGER AMOUNT. THE STRUGGLE

TO MAINTAIN HEAT AND SHELTER DURING THE WINTER MONTHS IN MISSISSIPPI IS A CONSTANT CRISIS SITUATION FOR AFDC FAMILIES. AGAIN, STATES WHO PARTICIPATE IN THIS PROGRAM SHOULD BE REQUIRED TO PROVIDE A MINIMUM LEVEL OF ASSISTANCE BASED ON A MORE EQUITABLE FORMULA THAN THE ONE WE ARE NOW USING. IF AN AFDC FAMILY LOSSES THEIR CHECK OR IT IS STOLEN OR THEY SIMPLY DO NOT RECEIVE IT AS A RESULT OF BUREAUCRATIC ERROR, THE CLIENT MUST WAIT A MINIMUM OF FORTY-FIVE TO SIXTY DAYS IN ORDER TO RECEIVE A NEW CHECK. THIS PARTICULAR POLICY CREATES EXTREME HARDSHIPS ON FAMILIES WHO MUST RELY ON AFDC FOR TOTAL INCOME SUPPORT. WE WOULD URGE SOME MODIFICATION WHICH WOULD ALLOW A FAMILY TO CONTINUE TO RECEIVE AFDC CHECKS WHILE THE VERIFICATION PROCESS IS UNDERWAY.

WITHIN THESE FEW MINUTES ALLOCATED BY THIS COMMITTEE I HAVE TRIED TO ADDRESS THE BROAD RANGE OF PROBLEMS REGARDING FOOD STAMP PARTICIPATION AND AID TO FAMILIES WITH DEPENDENT CHILDREN. THE MISSISSIPPI LEGAL SERVICES COALITION AND THE ENTIRE LEGAL SERVICES COMMUNITY IS AVAILABLE TO PROVIDE YOU WITH ADDITIONAL INFORMATION REGARDING THESE ISSUES. WE URGE YOU TO RETURN TO OUR NATION'S CAPITOL WITH FIRM CONVICTIONS TO ADDRESS THE POLICY INITIATIVES WE HAVE PROPOSED AS WELL AS THOSE THAT YOU ARE CERTAINLY AWARE OF IN REGARD TO THE IMPROVEMENT OF THE DELIVERY OF FOOD AND NUTRITION TO OUR NATION'S POOR.

THANK YOU.

Prepared Statement of Rims Barber, Director, Mississippi Children's Defense Fund

Members of the Select Committee on Hunger, I am pleased to once again come before you, although I am sorry that we must continue to hold hearings on such a basic issue as hunger in this Mississippi Delta. Despite the heat you felt while touring this area, I can assure you that this is not the "sunbelt". Perhaps it would be more appropriate to welcome you to the "Shadebelt."It is here that a higher percentage of people are left behind, dependent on government assistance, than almost anywhere in the nation. Hunger hangs over us, in large part, because we have not seen any of the economic recovery that occurred in other parts of the country. From 1983 to 1986 the unemployment rate in this five county area actually went up, from 15.1% to 16.0%. For the Black population of this area, times are even worse. One of every four Blacks are unemployed. Blacks are 62% of the population, 54% of the workforce, and 84% of the unemployed. Nearly half the Black population must rely on Food Stamps to survive. Therefore, whatever you do about our national policies to meet the needs of the hungry is very important to the lives of people here.

Life is better here than it was when the outside world first "discovered" hunger in the Mississippi Delta over twenty years ago. The poverty is less grinding today, although it is still poverty. Because we have struggled, with help from the federal

government, to open up opportunities for our people, there are some concrete improvements in life at this edge of the nation. Mothers are three times less likely to die in childbirth. Infants are less than half as likely to die and birth defects have been reduced by half. Children are half again more likely to stay in school and proceed to graduation. Civil Rights laws and federal programs have made a difference. Yet these are the only things that stand between many people and starvation and death.

While we have made progress, there are still barriers, still much left to be done. We are very proud of the improvements that have been made in the area of Infant Mortality. In 1983 the State Infant Mortality rate was 16.1 per 1,000 live births and 21.7 for Black infants. The 1986 rates are 12.3 for the total population and 16.2 for Blacks. Leflore County has made a most significant drop in black infant mortality from 31.4 to 19.8 in the three years since you were last here. Nevertheless, the Black infant mortality rates for this region are higher than many Third World countries. We still have a ways to go. We have made some improvements in securing access of needy people to Medicaid and other programs, yet barriers remain. We still get reports of three and four month delays in the eligibility process for Medicaid and Food Stamps, and struggle each year to secure the state funds to provide the services for our people.

There are no jobs. You can see closed plants all across this state. Thousands of people used to rely on small town factory work to support their families, but they can no longer see any hope that such jobs will return. Recently I was driving

through the delta and I saw a scene that reminded me of the old days: hoe hands spread across a large field chopping cotton. Just when we think that such grinding work is behind us, again it appears that farmers who can't make payments on machinery and chemicals are forced to recruit such labor and people are driven by hunger to accept such day labor jobs. Others seek out the only jobs available, part time work, passing hamburgers across a counter, never making enough to take their children to the fast food restaurant in which they work.

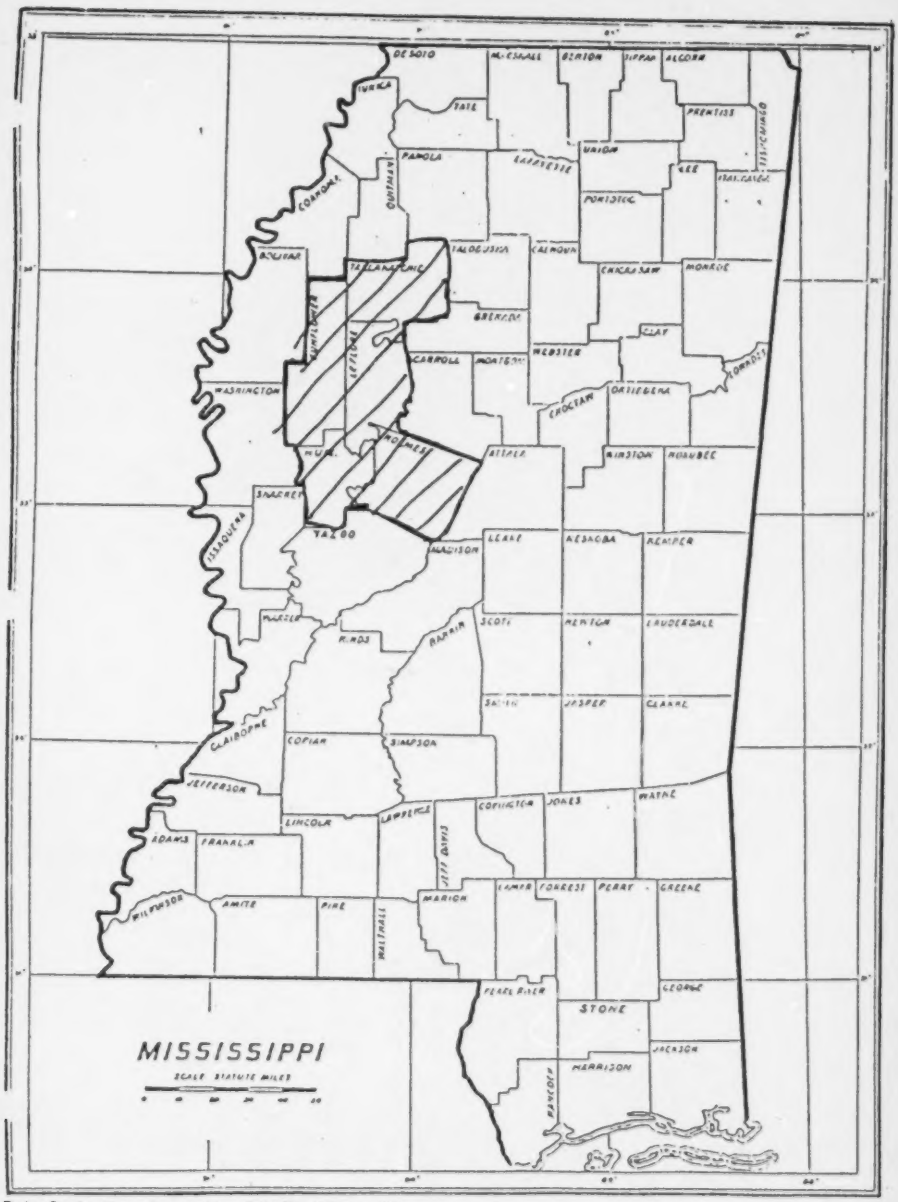
I am not sure what the answer to the jobs problem is, but trust that you Members of Congress will work on saving American jobs and bringing some economic life to this backwater of America. In the meantime, our people must survive. We must see that they have food and shelter. You can help by protecting the programs that provide federal entitlements to food and income assistance. You can work for housing programs that will improve the availability of decent housing, and provide some jobs producing that housing. You can also labor to see that congress does nothing stupid, that programs are not dismantled leaving people unprotected, that so-called welfare reforms are not passed that would force people to work at non-existent jobs. Any national program must work, not only in communities with good economic activity, but in places like the Mississippi Delta. Remember the things that you have seen here, (INSERT: STORY FROM HOME VISITS) the poverty, the lack of jobs, the lack of resources, so that you can ensure that Congress looks out for the needs of all Americans.

SELECT COMMITTEE ON HUNGER HEARING -- July 24, 1987 ** BASIC DATA

	Population '86)			Annual Ave. Unempl.			Food Stamps (5/87)		Children on AFDC	Infant Mortality Rates		
	Total	Black	%B	1983	1986	Blk86	H.H.s	persons	4/87	Total	1986	Black
MISSISSIPPI	2,631,010	925,610	35.2%	12.6%	11.7%	20.0%	169,004	512,515	125,423	12.3		16.2
Holmes	23,600	16,780	71.1%	18.0	22.5	30.8	3,763	11,689	3,545	13.8		13.3
Humphreys	13,890	9,110	65.6%	14.9	17.4	28.3	1,184	4,516	1,526	20.8		24.9
Leflore	42,600	25,180	59.1%	15.5	14.3	23.6	3,417	11,724	3,570	15.6		19.8
Sunflower	38,370	23,770	61.9%	13.5	14.6	23.2	3,001	11,348	3,090	15.1		19.1
Tallahatchie	15,760	9.030	57.3%	14.8	14.7	19.6	1,721	6,378	1,709	37.5		41.3
5 co. area	134,220	83,870	62.5	15.1	16.0	24.9	13,086	45,655	13,440	18.6		21.5

NOTES: Blacks are 62% of the population in the 5 county area; 54% of the workforce;
and 84% of the unemployed.
34% of the total population is on food stamps.

Sources: Mississippi Employment Security commission; Miss. Department of Public Welfare.



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RESPONSES TO QUESTIONS FOR RIMS BARBER

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. In past select committee hearings, we have heard testimony that the existing minimum wage rate is a disincentive for poor families to cease participation in public assistance programs. For many, it seems to be more beneficial, financially, to receive welfare benefits than to try to make ends meet on minimum wage earnings. What impact do you think an increase in the minimum wage would have on public assistance program participation rates?

Answer. The chart below shows the maximum hours that could be worked at minimum wage to quality for AFDC in Mississippi. Workers with incomes above these levels could, however, qualify for Medicaid and would qualify for food stamps.

NUMBER OF HOURS WORKED AT MINIMUM WAGE AND QUALIFY FOR AFDC

[Maximum hrs. per week]

Family size	At current $3.35	At $4.00	At $4.50
2	27	23	20
3	33	27	24
4	38	32	28
5	44	37	32

Looking at a sample recipient family of a mother and one infant, we would find that, in Mississippi, if she worked 100 hours in a month at the minimum wage, she would have $335 in earned income and would be eligible for $19 in AFDC for a total of $354 per month—plus Medicaid and food stamps, and perhaps WIC. If the minimum wage is raised to $4 per hour and she works the same number of hours, she would become ineligible for AFDC, but would retain Medicaid for her infant, food stamps, and perhaps WIC. She would have a monthly income of $400, or $46 more than presently. At a $4.50 minimum wage her income would reach $96 more than currently—same benefits as at the dollar level.

There are some families that would fit this profile, who would earn more than the basic AFDC eligibility levels if the minimum wage were raised. No one has done a precise calculation of how many families would fall into this catagory, but the number is less than 20 percent of the caseload. For these people, their increased earnings would deprive them of certain governmental benefits, but their earnings would offset those losses in most instances. Because many of these people would remain below the Federal poverty level, they would still be leading a struggling existence and could use governmental assistance. I would recommend that we establish Federal policy that certain benefits extend to all persons below the poverty level, and that the minimum wage be raised so that some people can escape poverty. The tradeoff is for self-sufficiency.

Question. How can Federal assistance programs be restructured to help those who are able to work achieve self-sufficiency?

Answer. The main reason people are not self-sufficient is that there are no jobs that will pay them wages that will enable self-sufficiency. At least that is true in Mississippi. Remembering the families that we visited together during the hearing, the problem was clearly lack of productive work. I don't believe that the current so-called welfare reform proposals before the Congress will have any impact on the lives of those people in Rome, MS, other than making it more cumbersome for them to get governmental benefits. They will still be hungry, without running water, and may be homeless by this winter.

We can save the children we saw from a life that replicates that of their poverty stricken parents. We can invest in health, nutrition, and educational programs that can enable opportunities to become realistic for them. I firmly believe that we must first deal with this preventive aspect, opening doors for those who have found them closed by societal, economic, and cultural barriers. Most of all, we must give these children hope.

There are certain ingredients that I believe should be in any welfare reform measure. First, adequate benefits regardless of the State a family lives in, and regardless of the family structure. Next, training and education must be tailored to the needs of the individual and the realistic prospects for employment. Services must be available, particularly for rural, isolated families, particularly if relocation is a part of

the goal. Case managers would be useful to help coordinate the services needed and to reassess the individual goals. Assistance for poor people is often piecemeal, lacks consistency and coordination, and fails to achieve reasonable goals.

Question. How integrated are Job Training Partnership Act (JTPA) projects with the AFDC and Food Stamp Program employment and training initiatives?

Follow-up: What changes would you suggest to improve the effectiveness of the activities?

Answer. The AFDC and food stamps employment and training initiatives that are currently in place in Mississippi are inadequate to achieve the goal of self-sufficiency for all but a very few temporary recipients. There is little coordination with JTPA. One CWEP pilot program, highly touted by the State Welfare Commissioner, began by recruiting clients whose profile was: half male/half famale, age 26, 2 years of college, no children, and some prior work experience. This was not representative of the food stamp general population. Similarly, some JTPA projects are creaming the client population so that they can have positive placement results. In a few instances, there have been attempts to coordinate these various programs. When these are coordinated with economic development, and various social services, there is the possibility of success. There needs to be an overall long-range planning body—or person—that can pull the various operating agencies together to work toward common goals for communities. Perhaps some solid coordination function could be placed in the responsibility of the Governor when programs are given to the States.

Question. How effective can workfare programs be in changing the poverty situation in Mississippi?

Answer. If by workfare programs you mean CWEP type programs where clients work off their benefits, then these will have little benefit in changing poverty. In the response above noted how one CWEP program creamed the client load. If our goal is to assist the hard core poor in places like Rome and Tutwiler, then CWEP will not work. The only thing that will work is new job opportunities.

Question. Job training can only be fruitful if once completed, the recipient can be placed in employment with wages adequate to provide a decent standard of living. What assurances do Mississippi job training programs provide that such employment will be available to those who complete training?

Answer. JTPA is putting significant emphasis on positive employment/placement success ratios. They are limiting the kinds of projects that get funded to provide training and the type of clients that can be reached/enrolled. With such high unemployment, it is difficult to construct programs that can assure clients that they will be a job waiting. If we are going to reach the so-called hard core poverty families, then the programs must have a more coordinated design to produce potentially self-sufficient workers and real jobs for them. The current programs appear to have a tension between placement and client outreach, that cramps their ability to produce.

Prepared Statement of C.N. Bennett, Yazoo City, MS

I want to thank you for allowing me this opportunity to tell you about my living situation and how I am affected by the food stamp program. I am a retired state employee. I retired ten years ago. I live with my disabled wife; our only income is from Social Security. I receive $462.00 per month and my wife receives $182.00 per month. Together, my wife and I have a total of $644.00 per month to live on.

My wife and I are both ill and require quite a bit of medicine each month. Our medicine (prescription and non-prescription) costs us approximately $125.00 per month. My other living expenses are:

House Payment	$75.00
Rural Ins. Co. (House Ins.)	$48.54
Nat'l. Sr. Citizens Ins. (Hospitilization)	$51.51
Wm. Bowen Ins. (Car)	$40.00
Public Ser. Comm. (Lights & Water)	$94.22
Miss. Valley Gas	$100.09
Telephone bill	$40.24
New York Life Ins. Co. (Life)	$15.20
Total amount of bills	$464.60
Medication	$125.00
Total Amount to pay each month	$589.60

As you can see by the time I pay the bills and buy medicine each month, I only have $54.20 left to buy gas for transportation and any other personal items my wife and I may need. It's very seldom that I buy anything other than food with the $54.20 because I only get $38.00 in food stamps each month. Believe me, you can't do very much at the grocery store with $38.00.

I don't have any children that I could get help from and my wife is too ill to leave alone for a very long time. Today, I had to ask someone to stay with her so I could come up here. My problem was worse before I went to see Congressman Espy and got some help with the cost of my wife's and my medicine. But, even with help on the medicine, it is still hard for me and my wife.

I am 75 years old and have worked for almost all of my life and paid taxes. Now, that I need some help, I am always told I can't get any because of my income. I wish someone would tell me how a person is to make it five years from now with everything going up and costing more when you don't have enough to live on now.

The elderly people here in Mississippi need some help with their medical needs and food; it seems there is no concern about how the old people get along anymore.

Prepared Statement of Alton B. Cobb, M.D., State Health Officer, Mississippi Department of Health

Mississippi has made significant improvements in its infant mortality rate in the last several years. This state has historically reported the highest infant mortality rate of all the states in the nation. The 1983 rate, which was the most current when the Select Committee visited in 1984, was 15.3 per 1,000 live births, once again the highest. However, Mississippi's 1986 rate of 12.3 is surpassed by two other states, South Carolina and Alabama.

The problem of high infant mortality is complex and the solutions, therefore, are just as intricate. There are numerous contributing factors to the problem, with interrelationships complicating the assessment of the problem and evaluation of interventions. The reduction in infant mortality experienced in this state is undoubtedly the result of concurrent improvements in several areas accomplished through the enduring efforts of many organizations, agencies, and individuals, both public and private.

Mississippi's health problems are intricately related to the state's socioeconomic and demographic characteristics, namely those of poverty, rurality, low educational levels, and high unemployment. Because of these same characteristics, Mississippi has not had the resources needed to properly address these problems. The federal government has provided the state with essential resources in the form of additional funds, manpower, and technical assistance. We at the state level have attempted to maximize limited resources and improve access to care through intensive targeting of resources, development of comprehensive high quality systems of care, and use of the most cost effective program delivery systems.

The Governor's Infant Mortality Task Force commissioned the State Department of Health to draft a four-year plan to address perinatal problems in the state. The Health Improvement Plan for Mothers and Children (HIP) resulted from this effort. This plan addresses four major areas: (1) prevention of unintended pregnancies, (2) comprehensive prenatal care, (3) access to maternity, infant, and preventive health services, and (4) regionalization of perinatal services.

The Department presented this plan to the Mississippi legislature during the 1987 legislative session, and the legislature provided authorization and funding to allow implementation of a large portion of the plan. Full funding was appropriated to implement the Medicaid expansion, recently authorized by Congress in SOBRA, to pregnant women, infants, and children under five whose family income falls below the federal poverty level. This program provides a good example of federal efforts which provide the states with flexibility and resources to target services in an effective manner. This Medicaid expansion will be phased in beginning October 1, 1987, starting with coverage of pregnant women and their infants in FY 1988. The state had previously

implemented an optional categorically needy program in 1985 and expanded the standard of need for Medicaid (and AFDC) to 50 percent of poverty in 1986. These combined efforts are expected to provide coverage for at least 7,000 more pregnant women and 46,000 more children when fully implemented.

The 1987 legislature also gave the State Department of Health authorization to coordinate the development of a regionalized system of perinatal care and an additional $100,000 appropriation for newborn transport, an important component of regionalization. Support for the agency's initiative in prevention of unintended pregnancies through a public health school nurse intervention program was illustrated through the passage of authorizing legislation and the addition of nine new positions.

The positive response of the state legislature to the plan is very encouraging. However, the state could not afford to fund many of the initiatives, including needed increases in the High Risk Maternity Program. Out of the initial request of approximately $9 million, the legislature was able to appropriate $3.7 million in state general funds for implementation of the plan. The recent federal supplemental appropriation for the MCH Block Grant will also provide valuable assistance to the agency in implementing these programs.

The State of Mississippi has chosen to utilize MCH Block Grant funds to provide access to prenatal care and delivery services to low income women. Through the statewide network of county health departments, more than 16,000 women receive their prenatal care, a figure equivalent to almost 40 percent of all live births in the state. The vast majority of these women are also eligible for and are receiving nutrition education and supplemental foods through the WIC program. Recognizing the value of this program, Mississippi has worked diligently at maximizing the utilization of WIC as evidenced by the state's high percentage of eligibles served (60 percent) and low cost per participant. The number of infants served by WIC is equivalent to 60 percent of all live births in the state. Mississippi's bidding procedures and unique direct distribution system allow the state to purchase the supplemental foods at low prices and distribute them at minimal cost. For example, we will be purchasing infant formula at 61 cents per can in FY 1988, compared to a retail price of approximately $1.40. There is a tremendous need for services provided through this program, and the state would certainly be unable to meet this need without federal assistance.

Mississippi would like to be able to provide similar nutritional services to the elderly population in the state. The agency applied for approval to implement a Commodity Supplemental Food Program directed toward the elderly, but regulations which require the program to first be directed toward women and children precluded serious consideration of the application. In a state like Mississippi where a large percentage of eligible women and children are being served through the WIC program, it would be helpful to be allowed a waiver from this regulation so that needed supplemental foods can be provided to low income elderly individuals.

In response to health care needs of the low income elderly population, the state does intend to propose the implementation of another component of the Medicaid expansion authorized through SOBRA, the coverage of elderly persons with incomes below the federal poverty level. By providing assistance to low income elderly in the purchase of health care and medication, the limited resources of these persons can be directed toward obtaining proper food and shelter.

Although the presence of hunger and malnutrition is evident to those who serve low income citizens, there is insufficient documentation of the extent of these problems in Mississippi. Numerous studies have been conducted nationwide to determine the prevalence of these conditions. A nutrition monitoring system which takes advantage of existing information systems would be a practical means of assessing the extent of the problem and evaluating intervention activities. Mississippi has recently submitted two applications to the Centers for Disease Control for funds to establish such systems: one for surveillance of severe pediatric undernutrition and the other for pregnancy nutrition surveillance. These systems would allow the agency to determine at an earlier point in time whether certain program activities are successful in improving the nutritional status of patients as opposed to waiting for longer term results to indicate progress. In addition, the pediatric surveillance system will provide for immediate intervention with individual patients to facilitate improvement in their condition.

We are proud of our state's improvements in infant mortality. However, we cannot afford to relax our efforts since we still have a long way to go. In 1986, of 41,868 births in Mississippi, 342 women still received no prenatal care. An additional 9,600 women received no care until after the first trimester of pregnancy. Furthermore, the infant mortality rate for nonwhites is still almost twice the rate for whites, and the percentage of births which are low birthweight remains relatively unchanged.

The State Department of Health intends to pursue implementation of the Health Improvement Plan for Mothers and Children as resources permit. We will also do our part in improving access to health care and nutritional services for other vulnerable populations such as the elderly.

Of course, implementation of successful programs requires considerable resources. The cost effectiveness of these programs is well-substantiated; by investing funds on the front end to provide preventive services, much larger expenditures are avoided in future years. The partnership of federal and state efforts directed toward common goals has proven value. When the federal government provides resources to poor states such as Mississippi and provides flexibility for the state to target these resources appropriately, successful and cost effective programs emerge.

Unfortunately, increases in federal funds have been considerably limited in the past several years. State, local and other funds have had to support many of the initiatives in the maternal and child health programs. On the other

hand, the discretion provided the state through the block grant mechanism and through structural changes in programs such as the revisions to the Medicaid law enacted through SOBRA have allowed the state to better target restricted funds. Special initiative funding through SPRANS (Special Projects of Regional and National Significance), authorized under the MCH Block (Title V of the Social Security Act), have proven helpful in testing alternative intervention strategies, of which the successful activities could be considered for continued support through other funds.

Thank you for the opportunity to provide this statement to you today. We in Mississippi look forward to the continuation of a successful federal/state partnership in the future to address the needs of our most vulnerable population groups.

SELECTED DATA ON MATERNAL AND CHILD HEALTH AND WIC
MISSISSIPPI 1983 - 1986

	1983	1984	1985	1986	PERCENT CHANGE 1983-86
INFANT MORTALITY RATE (IMR) Per 1,000 BIRTHS	15.1	14.4	13.7	12.3	-18.5%
RATIO OF NONWHITE IMR TO WHITE IMR	1.88	1.94	2.01	1.82	-3.2%
LOW BIRTHWEIGHT RATE	8.9%	8.8%	8.8%	8.6%	-3.4%
PERCENT OF BIRTHS WITH PRENATAL CARE IN 1ST TRIMESTER	74.3%	74.6%	74.8%	75.8%	2.0%
AVERAGE MONTHLY WIC PARTICIPATION	75,177	85,416	89,622	89,975	19.7%
MCH BLOCK GRANT AWARD	$ 7,504,049	$ 6,030,087	$ 7,224,014	$ 6,913,381	-7.9%
TOTAL MCH EXPENDITURES*	$12,184,195	$15,730,471	$15,618,517	$18,028,548	48.0%
WIC GRANT AWARD	$27,228,718	$31,049,010	$32,283,002	$33,624,931	23.5%
TOTAL WIC EXPENDITURES*	$27,974,017	$35,138,789	$35,569,753	$39,182,206	40.1%

NOTE: Fiscal data are on a fiscal year basis.

*Total expenditures include funds from all sources, including in-kind and indirect state and local support and third party collections.

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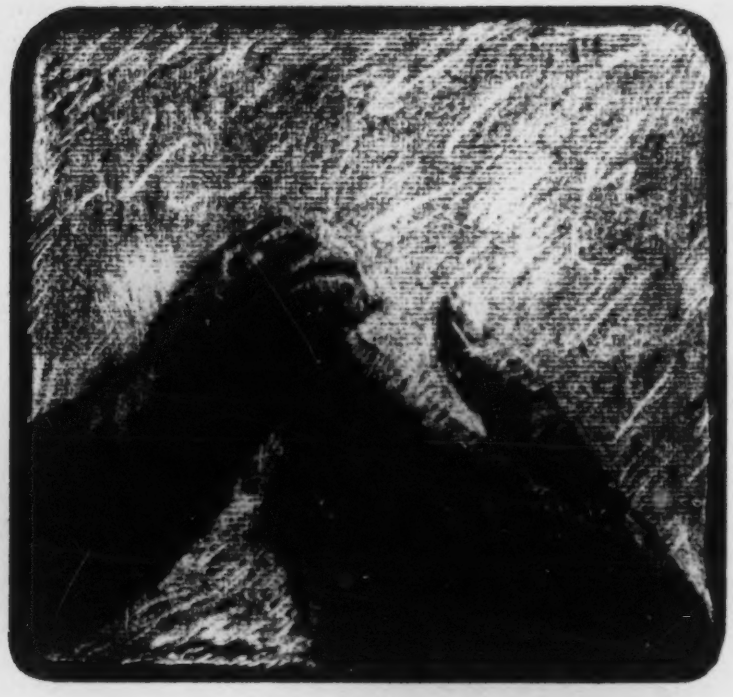

State Health Officer's Summary

Mississippi Health Improvement Plan For Mothers And Children,

(Mississippi HIP For Mothers And Children)

State Health Officer's Summary

Mississippi Health Improvement Plan For Mothers and Children (Mississippi HIP For Mothers and Children)

by Alton B. Cobb, M.D., M.P.H.

Mississippi has made significant progress in reduction of infant mortality, but infant death rates remain too high.

The teenage pregnancy rate in Mississippi has been declining for several years but also remains high. This contributes to increased infant deaths in addition to perpetuation of cycles of poverty and dependency, which often result from unintended teenage pregnancy.

If Mississippi is to further reduce infant mortality and teenage pregnancy, we must strengthen and enhance the existing prenatal care service delivery system; take steps to assure access for all pregnant women and infants to a high quality, regionalized system of perinatal services; and expand services for prevention of unintended pregnancies, with special emphasis on prevention of pregnancy for teenagers and for high risk women.

The Mississippi State Department of Health proposed a comprehensive four-year plan to address the problems of infant mortality and teenage pregnancy and to improve the health status for all pregnant women, infants, and children in Mississippi.

We are convinced that such a targeted, comprehensive approach will reduce the high rates of infant deaths and teenage pregnancy much more rapidly, thereby improving quality of life and moving the state forward as a caring and progressive people.

I. Access To Maternal, Infant, And Preventive Health Services

The problem of indigent care is large, but a major part is related to deliveries and care for high risk infants. Many Mississippians cannot afford the costs of advanced, highly technological services for maternity and pediatric care.

Recently enacted federal Medicaid program amendments permit states to extend eligibility, for pregnancy related services only, to all pregnant women whose family incomes do not exceed 100 percent of poverty. In addition, their infants may also be covered.

Coverage of these women does not require that any other services or payments be provided. Congress passed these targeted maternal and child health benefits in response to recommendations of the Southern Regional Task Force On Infant Mortality, which the Southern Governor's Association formed in 1984.

The Mississippi Legislature in its 1987 Session endorsed the Mississippi Health Improvement Plan For Mothers And Children through passage of SB 2641. This assures access to appropriate health care for pregnant women, infants, and children in need of such care by combining targeted Medicaid benefits with expansion of state-funded efforts aimed at high risk individuals not eligible for Medicaid.

With first year funding of approximately $15.5 million, including $3.5 million State funds and $12 million in federal money, an estimated 4,800 women can be covered. These "new eligibles" will be phased in, beginning October 1, 1987.

Medicaid expansion increases the number of reimbursable hospital days for children from 15 to 30.

The expansion increases physician fees, effective October 1, 1987, as follows:

- to $531.20 for a vaginal delivery
- to $637.57 for a C-section delivery
- to $100 for a pediatrician's attendance at all high risk deliveries instead of only certain high risk deliveries

Additionally, the expansion provides waivers

- to allow for purchase of durable medical equipment for Medicaid recipients who are not receiving home health services and
- to also reimburse hospitals which serve a disproportionate share of low-income patients.

II. Regionalization

A number of states have developed regional systems of perinatal health care services, with linkages among smaller hospitals which can safely and economically deliver services to most pregnant women and their infants (Level I hospitals) and larger hospitals which are equipped and staffed to serve pregnant women with increased risks of unfavorable outcomes (Level II hospitals). Most sophisticated care is available in Level III hospitals, usually large teaching hospitals located at medical schools.

Specialized transport systems move patients among these three levels of care as needed.

The systems have demonstrated lower mortality and also reduced the number of other undesirable outcomes. Additionally, such systems cost less because regions avoid duplication of expensive facilities, highly trained personnel, and equipment.

SB 2642 authorized the Mississippi State Department of Health to coordinate the development of such a system in Mississippi.

III. Unintended-Pregnancy Prevention

The teenage pregnancy rate in Mississippi has been slowly declining for several years but remains high. Significant reductions in this rate will contribute to reductions in infant deaths. Furthermore, such reductions will reverse the cycles of poverty and dependency which often result from unintended teenage pregnancy.

Broad-based health education linked to public health nurse services produces healthier teenagers and reduces the rate of teenage pregnancy. Outreach and education are critical in protecting our children at such a susceptible time period.

The Mississippi Health Improvement Plan For Mothers And Children proposes funding to begin the phase-in of education, outreach, and nurse services for adolescents in grades seven through nine statewide. Although the Legislature appropriated no money for this project, about $250,000 is available for the 1987-1988 school year.

Placing public health nurses in the school to work directly with students has already proven cost-effective. In pilot projects in the Meridian and Greenville areas, public health nurses directed health education toward prevention of pregnancy and promotion of healthful and responsible life-styles for adolescents. They provided health screening, nutrition education, child abuse/neglect detection, first aid, and counseling in the areas of drug and alcohol abuse and mental health. The nurses also referred students who needed other professional services.

One school nurse, who can provide care for 750 students, costs approximately $16,000 each year—just $22 per student. In the Meridian-area pilot project, teen pregnancies dropped from 56 in the year before the project to 12 in the first year. Based on Mississippi vital statistics and projected costs of care, one public health nurse in the school system can prevent future costs to the state of over $700,000.

PREPARED STATEMENT OF AGNES HINTON, REGISTERED DIETITIAN, DIRECTOR OF NUTRITION SERVICES, MISSISSIPPI STATE DEPARTMENT OF HEALTH

Thank you for the opportunity to present a statement to you today, as I did three years ago at the Greenwood hearing. Dr. Cobb has told you of some of the progress we as an agency and as a state have been able to make in the areas of access to adequate prenatal care and reductions in infant mortality, but has also pointed out that many problems remain. As I thought back over my testimony of three years ago, I was struck by the number of recommendations I made in 1984 which are yet to be implemented, the need for many of which has only grown more critical.

The following are some of the key areas where I feel changes must be made:

1. Food assistance programs must be improved to better meet the food and nutrition needs of our population.

   - The Food Stamp Program should be increased by 25%, outreach programs for the new poor should be required, and each state should be encouraged to develop a nutrition education plan as allowed by federal regulations. Nutrition education efforts should be expanded for food stamps, including an increase in the Expanded Food and Nutrition Education Program (EFNEP).
   - Funding for WIC should be increased. The 1986 report of the Council on Maternal, Infant, and Fetal Nutrition, the Advisory Council for WIC and the Commodity Supplemental Food Program (CSFP) on which I serve, includes the recommendations that WIC be expanded as soon as possible to serve 50% of the potential population and that each fiscal year an additional 10% of eligibles be added until all are served. All current nutrition education components should be maintained.
   - In the National School Lunch and Breakfast Programs, funding and eligibility guidelines must be raised to allow more

participation; the reimbursement rates for school breakfast must be increased; and the program implemented in all schools with a large number of children of low-income families.

- Elderly Nutrition Programs must be rapidly expanded to meet the tremendous needs existing among the low-income elderly. Also, dietary consultation should be required at least at the state level for these programs to ensure that food dollars and education opportunities are maximally utilized.

2. We need continued involvement of private and voluntary agencies and churches. The growth of food banks, food pantries, and emergency feeding sites has been most helpful. The political activism of groups such as Bread for the World, who have chosen increased funding for WIC as a top 1987 legislative priority, is encouraging. All of these efforts must be continued and expanded, where possible.

3. A nutrition monitoring system for our population must be instituted, and undernutrition should become a reportable condition. Despite efforts by a broad coalition of over 70 public health, scientific, professional, voluntary, industry, and advocate groups as well as representatives of state and local governments, a nutrition monitoring bill has yet to be signed into law. In late April, the National Nutrition Monitoring and Related Research Act of 1987 was introduced as S. 1081 and H.R. 2151. This legislation would mandate for the first time a coordinated interagency and intergovernmental system, structured to meet the expanding needs of federal and nonfederal entities for health, nutrition, and dietary information.

Enactment of this legislation will maximize the benefits of existing federal monitoring activities. It will increase the ability to address problems of food assistance and undernutrition, diet and disease prevention, health care cost containment, food safety, and nutrition education. Passage of this legislation should be a top priority of this committee.

4. Sufficient nutrition education must be available to enable our population to make informed, appropriate choices regarding their food intake. While hunger and malnutrition often are caused by a lack of access to an adequate food supply, ignorance of basic nutrition principles and vulnerability to nutrition quackery are also factors. As mentioned, all federal food assistance programs should have a nutrition education component. Additionally, sequential nutrition education should be included in K-12 school curriculum materials. Another need is for required nutrition education components of various professionals - particularly teachers physicians, dentists, and nurses. One university in Mississippi now requires that all graduates pass a basic one-hour course in nutrition. Ongoing inservice education programs in nutrition also must be available to keep abreast of current knowledge, especially for health professionals and teachers.

Yet we are making progress. As Dr. Cobb mentioned, we've applied to the Centers for Disease Control for grant funds to begin both a Severe Pediatric Undernutrition Surveillance System and a Prenatal Nutrition Surveillance System - grant dollars which I understand this committee helped secure. We are beginning a very exciting project in the Mississippi Delta in Conjunction with the Cooperative Extension Service's EFNEP Program and the Meals for Millions/Freedom From Hunger Foundation entitled Partners in Improved

Nutrition and Health. I'm submitting a more detailed description of this project for the record. Project goals are to bring about local self-help activities that yield sustained improvements in the diet and health of low-income residents and to establish models for self-help nutrition and health improvement which are suitable for replication in other areas. These goals are to be achieved over a five year period.

I believe that a serious problem of inadequate access to food and in many cases hunger exists in our state as well as in many areas of our county. This problem must be addressed through both immediate and long-range interventions which involve private efforts in addition to those of state and local government. However, I believe that the federal government must assume primary responsibility for leadership and resource allocation to solve this national problem.

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PARTNERS IN IMPROVED NUTRITION AND HEALTH:
A JOINT PROGRAM BETWEEN THE MISSISSIPPI STATE
DEPARTMENT OF HEALTH, THE MISSISSIPPI COOPERATIVE
EXTENSION SERVICE, AND MEALS FOR MILLIONS/FREEDOM
FROM HUNGER FOUNDATION

Program Design: Inter-Agency and Community Partnerships

The first goal of this Program will be to bring about local self-help activities that yield sustained improvements in the diet and health of low-income residents of one or more rural counties in Mississippi. The second goal is to establish models for self-help nutrition and health improvement which are suitable for replication in other parts of the rural South.

These goals are to be achieved in a five-year period with an option to extend for one to five additional years.

The program area and population will be within the Delta/Hills Public Health District III. Not all nine counties of this public health district are expected to participate in the program, but all may participate. Other counties within the State of Mississippi may be included in the expansion/replication phase.

Specific Design Features

The Program will start with two experimental projects, one in Humphreys County, the other in neighboring Leflore County. The primary program focus is on Humphreys County, because of its relative need for attention and its suitability as a pilot area for activities in the whole of the Mississippi Delta region of Arkansas, Louisiana, and Mississippi. The project proposed for Leflore County is subsidiary to the one for Humphreys County.

The Humphreys County project emphasizes the development of community-agency partnerships. The initial purpose is to provide community-based nutrition and health education and improve the effectiveness of existing agency programs for the low-income segments of the county population. At first, the project targets neither particular segments of the low-income population, nor particular nutrition-related health problems. Instead, the project is designed to create a mechanism for dialogue between the county-based service agencies and the informal leadership of the low-income communities of the county. The dialogue is intended to lead communities and agencies to:

-- identify more clearly the local nutrition, health, and other poverty-related problems,

-- build consensus for action, and

-- plan and carry out specific community-based projects which use self-help and mutual-help to address the problems.

The community-based projects are expected to target specific problems in specific segments of the county's low-income population. Some likely target

problems or needs, as identified in a preliminary meeting of community and agency leaders (January 1987), are training and education for better health and job skills, transportation to services and jobs, job creation, child care for teenage or working parents, sex education and teenage pregnancy prevention, commercial and household vegetable production, drug abuse education and prevention, and school health screening.

The Leflore County project is narrowly targeted on high-risk pregnancy outcomes and infants and emphasizes the development of a partnership between the State Department of Health and the Cooperative Extension Service. The project is designed to conduct formal research to evaluate an integrated inter-agency approach to dealing with high prevalence of low birthweight and infant mortality among low-income people. The research results will be used to enhance the Humphreys County project, as well as offer a model, if successful, to other counties in Mississippi.

Both projects could be tried in one county. However, the Leflore County project requires a large number of pregnancies each year, more than will be found in Humphreys County. The Humphreys County project requires a smaller, more rural population than is found in Leflore County. Also, it is likely that the two experiments could interfere with each other and confound the evaluation results. Therefore, it is advisable to carry out tne projects in separate counties until the experimental evidence indicates which elements are successful and suitable to be combined in the same county.

These two county projects are the 'entry points' for the Partners in Improved Nutrition and Health Program in Mississippi. They provide the opportunity to offer the initial two counties some concrete action on recognized problems. At the same time, they allow the collaborating agencies to learn the structure and culture of the communities and assess their needs and priorities through the eyes of community members. The Humphreys County project, in particular, enables communities and agencies to evaluate experience with the initial projects and draw conclusions about the needs and means for further action. In addition, each county is expected to borrow successful elements of the other county's initial project.

The initial program focus in both counties is on health. Because health issues are recognized by the communities as needing high priority attention and because these issues are not strongly associated with intra-community divisions or tensions, health is a relatively easy sector in which to develop broad community dialogue, consensus and support. The confidence and relationships developed in the health sector can be built upon to move into other sectors with new projects. The Mississippi Program is expected to bring a variety of disciplines and techniques to bear on the nutrition-related health problems identified by the communities -- through a diverse but integrated set of projects. Integration will come from the mechanism created to involve agencies and communities in project development.

The role of the Meals for Millions/Freedom from Hunger Foundation will be to facilitate coordination among agencies and development of the mechanism for agency-community dialogue. The Foundation will also manage the research and evaluation aspects of the program. It will assist project development by:

-- identifying and adapting/developing appropriate project designs and education/training materials,

-- providing initial training for local agency staff and community members, and

-- connecting the local project leaders to other sources of technical and financial support within or outside the state.

The Foundation will provide three staff in-state, as well as support from headquarters staff and consultants. The in-state staff provided by the Foundation will operate under the administrative umbrella of the State Department of Health in Humphreys County and the Cooperative Extension Service in Leflore County. One of these staff will operate as overall coordinator of the Program and coordinator/facilitator in Humphreys County. Another staff person will work for three years as the research and training coordinator in Leflore County. The third person will be the office administrator, in support of the other two and their activities. Preference will be given to hiring qualified Mississippians.

The proposed structure of staff and support includes a state-level Committee of Advisors, to be convened by the Foundation, but chaired by the Director of Nutrition Services, Mississippi State Department of Health. The membership will include individuals active in both public and private endeavors to deal with health and poverty issues in Mississippi. Their interests should be statewide rather than focused on the counties directly involved in the program. Their initial mission will be to advise the Foundation and its collaborators on program design and staff recruitment. As the program develops, the Committee members will monitor progress and participate in the interim and final evaluations. If the evaluation results are encouraging, the members will be asked to assist in disseminating the results and in promoting replication of the program's successful components in other parts of the state.

MEALS FOR MILLIONS/FREEDOM FROM HUNGER FOUNDATION

The Meals for Millions/Freedom from Hunger Foundation is a non-profit development organization without church or government affiliation. Its mission is to create opportunities for low-income people in developing communities in the United States and abroad to recognize and develop their potential to solve their own nutrition-related health problems.

Meals for Millions was founded in 1946 as a relief agency to produce and distribute Multi-Purpose Food, a protein/vitamin/mineral-enriched food supplement. Distribution was worldwide for almost thirty years. In the early 1970s, however, Meals for Millions shifted from food distribution to promotion of self-help development as a more viable long-term solution to malnutrition. In 1979, Meals for Millions became successor to the American Freedom from Hunger Foundation and adopted the name Meals for Millions/Freedom from Hunger Foundation.

Funding for Foundation programs comes primarily through donations from private individuals, churches, and businesses and secondarily through grants from private foundations and corporations, and for programs outside the U.S.,

through the U.S. Agency for International Development (approximately one-quarter of all funds).

The Foundation currently operates what it calls Applied Nutrition Programs in Africa (Kenya, Ghana, Sierra Leone, Togo, and soon to start in Mali), Asia (Nepal and Thailand, and soon to start in Indonesia), Latin America (Bolivar, Ecuador, and Honduras), and the United States (Arizona). Programs in Antigua (Caribbean) and South Korea are currently graduating to independence from Foundation funding and management, as intended in all Applied Nutrition Programs. These programs are operated in close collaboration with government and community organizations, involving local leadership in identifying nutrition-related health problems and planning projects that encourage community participation in solving the problems.

Priority problems around which specific projects are built vary depending on the circumstances of the country and the culture and perceptions of the participating communities. Examples of specific projects include promotion of improved small-scale farming/gardening techniques, establishment of revolving loan funds to promote small enterprise development, low-cost home sanitation, infant growth and health monitoring, breastfeeding and weaning food education, and school nutrition education. Any or all of these types of project may be found within an Applied Nutrition Program. However diverse the projects may be, they are integrated through mutually supportive focus on the nutrition and health needs of the participating communities.

For the few positions supported by the Foundation in the state or country, strong preference is given to hiring qualified people from that state or country (or at least nearby). Through these local staff people, supported by central office staff in Davis, California, the Foundation offers management and technical assistance for project planning; education and training for implementation; and to judge progress toward project objectives, collection and analysis of data for monitoring during the project and evaluation at the end of the project.

Strategy for the United States

The persistence of the "malnutrition syndrome" as both major cause and effect of American poverty can be well documented. An analyses of anti-poverty programs indicate that the programs need more than additional funding to meet all the needs. Poor integration/coordination of services, inadequate outreach to those in need, and development of dependent or opportunistic behavior by program beneficiaries were cited as persistent shortcomings in program effectiveness. The nutrition and health-related programs need to experiment further in building partnerships with each other and with individuals and communities to promote self-help and improve program effectiveness.

The elements of the malnutrition syndrome and the promotion of self-help through program innovation are well within the experience and commitment of the Foundation. There is certainly need for the kind of contributions that the Foundation makes in its Applied Nutrition Programs. The strategy is the same as overseas, but certain aspects need greater emphasis in the United States.

In other countries, the geographic coverage of operating agencies may be spread so thin that the Foundation is directed to an area almost unserved by any agency. There are no such areas in the United States which are not also very thinly populated. Even remote rural areas have some services from a large number of agencies, each to some extent jealous of its "turf". To be effective, the Foundation must put a higher than usual premium on collaboration and coordination with these agencies in the United States.

Given the size of the United States and its poverty population and the tiny size of the Foundation budget compared to the many billions of dollars spent each year in a multitude of anti-poverty programs, what role can the Foundation hope to play that will have any impact on malnutrition and poverty in America?

The catalytic role. There are serious problems to be solved, but most agencies and communities are not in a position to undertake the risks of experimenting with new approaches that may fail. That is the unmet need that the Foundation can meet better than the operating agencies or the communities. Of course, the agencies and communities must participate as partners in the experiment, but in the most risky, most experimental stages, the Foundation can shoulder the major responsibility. The Foundation also has a comparative advantage over more specialized, discipline-focused agencies, because its Applied Nutrition Program design provides a mechanism for integrating, or at least coordinating, a variety of disciplines to focus on malnutrition problems and the underlying, poverty-related causes, which are many and diverse.

Most U.S. programs at the federal level started out as local or state experiments leading to national acceptance. Thus, American experience shows that the catalytic strategy is sound, that the Foundation has a good chance of significantly benefiting the American poor far beyond the direct impact of its own experimental programs.

Focus on the Rural Poor in Four Ethno-Regions

The Foundation carried out a strategic assessment of poverty and malnutrition in the United States (Gwynn, Dolber-Smith, and Dunford 1986). The authors compared the rural and urban poor and recommended that the Foundation focus on the rural poor. First, the Foundation's experience to date has been almost solely with rural poor populations. Second, the rural poor in the U.S. have had considerably less access to services from government agencies (with the exception of the Native Americans living on reservations), and therefore, have been neglected relative to the urban poor. Third, because of less access to services and greater stability of their communities, the rural poor have maintained a stronger self-help ethic as well as stronger neighborhood mutual-helping networks. In short, the rural setting is familiar to the Foundation and social conditions are relatively conducive to the self-help approach. Adhering to the first rule above, the Foundation has chosen to focus on rural poverty in the U.S. as well as overseas.

The strategic assessment analyzed the populations of rural poor into four "ethno-regions". These ethno-regions represent four types of high-poverty

rural counties that are distinguished by ethnic differences in their poverty populations and that cluster geographically as follows:

- Deep South (states = AL, AR, FL, GA, LA, MO, MS, NC, SC, TN -- predominantly black poverty but considerable numbers of whites as well)

-- Rio Grande Valley (CO, NM, TX -- predominantly Hispanic poverty)

-- Appalachia and Ozarks (KY, TN, MO, AR -- almost solely non-Hispanic white poverty)

-- Four Corners and Dakotas (AZ, NM, UT, ND, SD -- predominantly Native American poverty)

The "Deep South" has by far the majority of the rural poor (62.6%). Adhering to the second rule above, the Foundation has chosen to focus new U.S. programming initially on rural poverty in the "Deep South" ethno-region.

Focus on Poverty in the Rural South

Based on further data analysis in Gwynn et al (1986) and site visits and interviews with government officials and community activists in Arkansas, Georgia, and Mississippi, the Foundation has chosen to locate its next U.S. Applied Nutrition Program in the State of Mississippi. The Foundation analysts feel that Mississippi is representative of conditions in the rural South and has both great need for assistance and enthusiasm for collaboration with the Foundation in the nutrition and health field.

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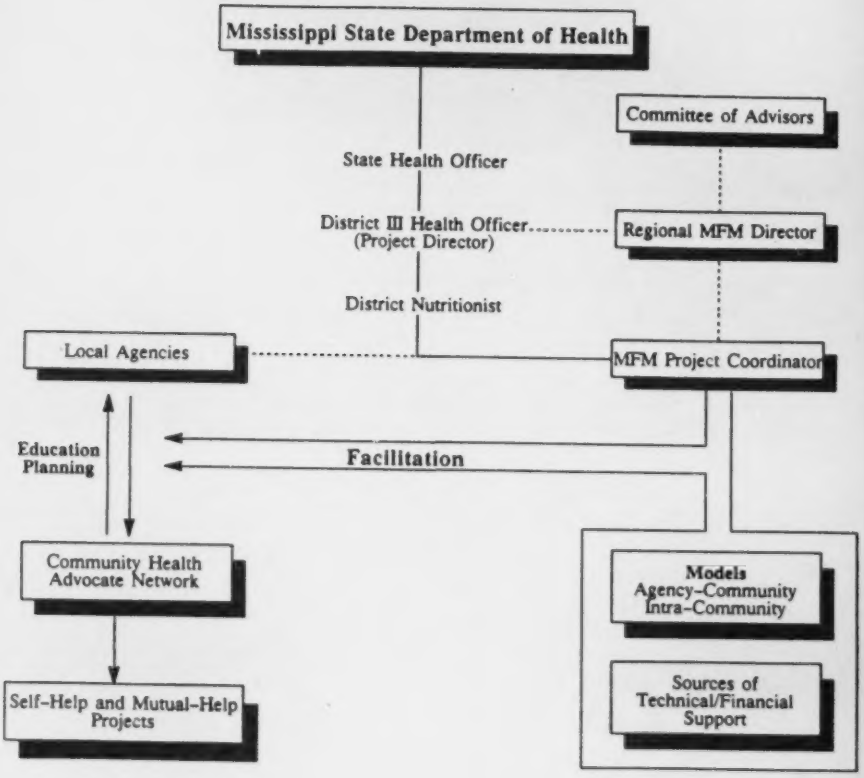
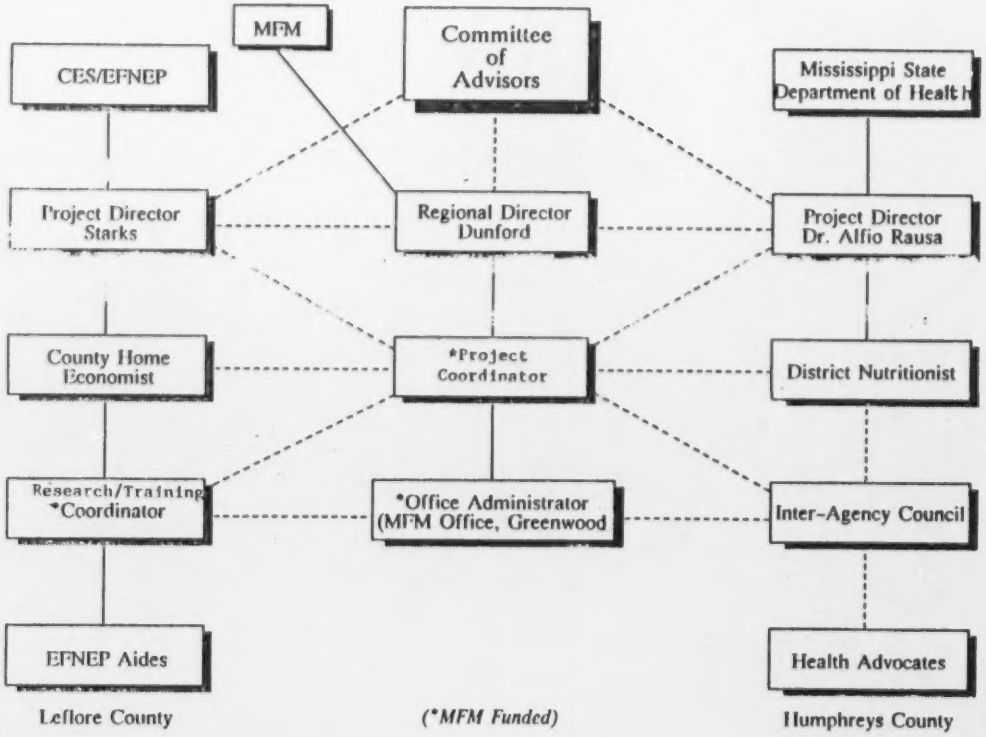
Humphreys County Project



Partners for Improved Nutrition and Health



5-15-87

RESPONSES TO QUESTIONS FOR AGNES HINTON

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. How are rural residents in your health service area referred to the WIC and other food assistance programs?

Answer. The WIC Program, through the county health departments or community health centers, accepts referrals from any program, including self referrals. Outreach information is shared with potential community referral sources, such as the Department of Public Welfare, AFDC and food stamps, community action agencies, community health centers, private physicians, Headstart, and other day care providers. Outreach information is also prominently placed in businesses or locations accessible to the low-income population, such as grocery stores, laundromats, drug stores, court houses, libraries, et cetera. Word of mouth referrals from friends, neighbors, or relatives is another common referral mechanism.

Question. What are the most prevalent nutrition-related maladies among your clients, especially among low-income children and elderly shut-ins?

Answer. Anemia, underweight, overweight, low birth weight, and inadequate dietary intakes are among the most prevalent problems we see among low-income children. Dental caries are also a tremendous problem.

Underweight, overweight, anemia, osteoporosis, dental problems, susceptibility to infection and delayed healing of wounds are among the nutrition related health problems we commonly see among the elderly, especially those who are nonambulatory.

Question. Based on your experience, how frequently are elderly clients forced to make a choice between paying for medical care and purchasing food supplies?

Answer. While this is difficult to quantitate, I do believe it is a real and growing problem among the elderly.

Prepared Statement of Sister Anne Brooks, D.O., Physician, Tutwiler Clinic

HEALTH PROBLEMS SEEN IN MY PRACTICE WHICH ARE ASSOCIATED WITH INADEQUATE NUTRITION

I INADEQUATE NUTRITION
- A Lack of protein
- B Not enough meals
- C Poor knowledge of nutrition

II HEALTH PROBLEMS (ADULTS)
- A Obesity
- B Cachexia

III HEALTH PROBLEMS (INFANTS, CHILDREN)
- A Overweight
- B Failure to thrive

PROBLEM: Inadequate nutrition: lack of protein

A fairly large number of patients, when questioned about their food intake specifically,will have had a "neck bone" or a "wing" whichthey cook up with their greens all week (same neck or wing).

Others are woefully ignorant of sources of protein, or wait until they catch a fish.

EXAMPLES:

A 20 year old girl, who weighs 237 lbs, eats the equivalent of twenty servings of bread daily. Her one bit of protein daily is a piece of baloney.

PROBLEM: Inadequate nutrition: inadequate number of meals

Many patients do not eat breakfast.(This is not restricted to the Delta.) I have encountered countless fieldhands who eat once a day, sometimes not until evening. In some cases only one meal is prepared, but the family members will snack during the day, usually on junk food. Or the mom will send the child to the store with food stamps to get breakfast, and the child will come home with pop and chips. During the summer it is not unusual for a school age child to eat at the summer feeding program and not have any other meal that day.

Meals brought to the elderly by programs such as "Meals on Wheels" are frequently the only meal that person gets, and part of it is carefully put away for "before bed" or the weekend. In some cases this is becuase the elderly person really is incapable of caring for him/herself and is barely surviving (There are more of these folks that you think). In other cases the person is too fatigued or too depressed to take the trouble to prepare a meal just for one person. In many cases they have used their meager check to pay for medication and have nothing left for food.

EXAMPLES:

A 24 year old mother of 4 eats only a noon meal. She had been brought up that way, and as soon as her children were off the bottle, she fed them once a day.

Lugene's family has only one cooking pan and one spoon. They cooked what they had, and all stood around and ate out of the pan with their hands. Someone sent us kitchen items, which we gladly took over to their shack with some plates, but they weren't too enthusiastic about the plates, as they had to haul their water and would have to wash the plates. But they were glad to have the forks and spoons.

A 67 year old lady was dying from cancer. About the only thing she would take was buttermilk, into which we put some protein supplement powder. Each time we went to her house, we checked the refrigerator to see how much she had taken of what we had brought her. Each timo it was empty, in spite of the amount we brought or the frequency of visits (like three hours apart). Three children she was "raising", no kin of hers, were never fed at home, and would come to eat whatever was available in this lady's ice box.

PROBLEM: Poor knowledge of nutrition

A sadly large number of my patients have no idea what constitutes a balanced diet, even those who have had some schooling. Meal expanders such as pasta or rice actually are the meal, with maybe a little of something added. Or greens and cornbread will be the meal. Some families eat all their food fried. And in most cases, meals are supplemented with junk food and pop.

EXAMPLES:

A 34 year old mother of three had been feeling poorly, and in an attempt to define her problem, she was asked to come into the clinic at 8am for a blood test. As she had no one to leave her children with, she brought all of them with her. I looked out into the waiting room to see her sitting with the baby in her lap, her 3 year old and 6 year old sitting beside her. Each of the children had a bag of potato chips which they were happily eating and feeding the baby. That was their breakfast.

A 32 year old working man was very cooperative in keeping a diet diary for our diabetic teacher. His only source of protein was turkey necks; he didn't know it was protein, but he did say he had enough money for food.

Some families (seemingly too few) have summer gardens. What they eat is what they grow; most of the time they do not "put any up" as there is a lack of refrigeration/freezer space, jars, baggies, etc.

PROBLEM: Obesity

This is by far the most devastating problem in my practice, as well as the most common problem. There are several diverse reasons.

One of the most common reasons is lack of dental care. I look to check someone's throat and find teeth black and rotted to the gums. Gums are red and swollen from pyorrhea, teeth are loose. Elderly have shrunken gums, teeth absent for years, whose once well-fitting dentures are too loose and painful to wear. There is no fluoride in anyone's water. Many people do not have toothbrushes and think toothpaste is too expensive to purchase. Babies are allowed to lie on their backs with milk bottles in their mouths. When first teeth rot, second teeth can develop cavities even before they erupt.

When your teeth or gums hurt, you eat soft foods, most of which are pastas, full of starch.

Another prominent reason for obesity is high starch intake, high fat and junk food consumption. This is often due to ignorance, not only of food groups, but of how to budget and stretch money and food stamps.

Results of obesity are multitudinous and often disastrous. Weight gain raises blood pressure, particularly in a population whose genes carry a tendency toward hypertension. High blood pressure causes the heart to enlarge, leading to heart failure, heart attacks; blood vessels can't handle the load and kidneys begin to fail, clots form, there is a vastly increased risk of stroke. It is, simply, tragic.

EXAMPLES:

Maggie, age 73, weighs 237lbs. She has had three strokes, and is a helpless invalid. Her caregiver has multiple sclerosis and is doing the best she can (which is poor) but there is no room in any nursing home. Maggie has medicaid and medicare, but a paying patient from New Orleans got the only female bed available when Maggie was able to leave the hospital. She has bedsores, problems with diarrhea for days on end, frequent pneumonia.

Rachel came in with a pressure of 240/160. She had no income. I had to put her in the hospital, where half an hour later she suffered a seizure from the pressure in her brain. Two days later she had about 1/50 of her kidneys functioning. Possibly because she was young (38), even though she was 228 lbs, she responded to medication. She is on four different medications, but her kidneys have improved and her pressure is controlled.

Sidney, age 42, came in with a pressure of 190/140. He had just finished three days as a tractor driver at the beginning of this season. He had stroked out because he had no money for pressure medicine. He is completely paralyzed on his left side. It took 7 weeks to get food stamps. He cannot get disability for another 3 months. During the time he had no food stamps, his sister-in-law prepared food and brought it to him daily. We had his electricity turned on with money that had been donated to us for the needy because you can't survive in a shack on the edge of a rice field in the summer without a fan.

PROBLEM: High blood pressure

Blood pressure can be controlled in many different ways, the most healthy of which is diet. Salt is notorious for holding fluid and raising pressure. Salt is found in enormous amounts in theAmerican diet, but more so in the diets of those eating junk food. It is also present in high amounts in the commodity food distributed to those on food stamps--cheese.

EXAMPLES: Failing control by diet, a patient is placed on medication. There is a state health department program for hypertension, where three or four medications are available at low cost for those who qualify. It takes three to four weeks for the medicine to come from Jackson. The pills are generic; for several months they were all white. This led to problems like Willie had: I said, "Do you take your pressure medicine?" "Oh, yes'm. I takes my white tablet every morning." Do you have another tablet?" "Oh, yes'm. I takes my other white tablet twice a day." "I think you have three different kinds. What about the other pill?" "Well, I takes the third white one three times a day." But Willie couldn't read, and he was really messing up. I was fit to be tied!

Many people require different medications, as those provided by the health department have sometimes intolerable side effects. (I have a 42 year old field hand who has become psychotic as a result of taking Reserpine; it is knowto cause depression. The psychiatrist does not think Joe Willie's depression will resolve, even though he has been off that medication for two years now.) Because of this, or because their pressure simply does not respond to those medicines, patients may be placed on newer or different pills. Elderly whose incomes do not allow SSI and medicaid (which pays for 4 Rx/month) are saddled with medicine bills sometimes over $150/month. More than one has come to me saying, "Doctor, I couldn't get my precious medicine this month 'cause I had to buy me some food." What can I say? Their pressure is sky high, they're next in line for a stroke, but they're hungry.

Certain blood pressure medicines, diuretics,("fluid tablets"or "water pills") cause the patient to lose potassium with the water. This leads to a potentially dangerous situation, as potassium is essential for the heart to beat regularly. Most of my patients do not get much potassium in their diets (bananas and orange juice, common sources, are too expensive). So frequent lab tests are needed to watch the level, and potassium, either in tablet or liquid form has to be prescribed. The problem with the liquid form is that while it is much cheaper, it tastes terrible, and many people do not know what a tablespoon is, or do not have one to use. The dose is thus inadequate and the potential for heart problems increases.

EXAMPLES:

Ethelean, 255lbs, age 67, came in with problems breathing. She was grey, panting, and very anxious. Her chest x-ray looked clear, her cardiogram showed some early coronary artery disease, but it was not until we got an echocardiogram of her heart in the hospital that we found her heart to be badly dilated and hardly pumping. Her usual blood pressure is 190/110; she hasn't had medicine "in years-I can't afford it." Her pressure is better; she will have to afford her medicine but she can walk only across the room before she has to sit and catch her breath.

Joe, a 38 year old farm worker, came in with terible chest pain. His cardiogram showed a large heart attack. He knew he had a problem with "high blood", but had spent money on food for his family of 7 and not on the medicine he knew he should have been taking. He has now recovered from his heart attack, but it has left him with such a weakened heart he has had to go on disability. He now fishes for the family.

PROBLEM: Diabetes

Diabetes is a medical condition where the person either has no insulin or not enough to escort the sugar into the cells where it belongs. The body changes all vegetables and starches into sugar; in order to be utilized, it must go into the body cells. When a person becomes obese, the amount of insulin produced doesn't change, but the amount required does. In these patients, a tablet can be given that pushes insulin-producing cells to make more insulin, or helps increase the sites where insulin can bind to do its job. In other situations, the body doesn't make insulin and the patient's sugar level is controlled only with daily injections of insulin.

Insulin is made from pork and/or beef; many patients are allergic to these forms. (This kind costs about $9 a bottle.) Recently a human-derived insulin called Humulin has been developed ($12+/bottle) In either case the patient needs a refrigerator (and electricity) and special insulin syringes (about $6/month). It is important that the patient not inject in the same place daily as that area becomes scarred and the insulin doesn't absorb; it is also crucial that the patient follow a balanced diet no matter what type of medication is given.

There is no state-directed program for diabetes medication.

Effects of Diabetes are body-wide. Uncontrolled sugar leads to kidney damage, visual impairment and eventual blindness; diabetics frequently experience numbness and tingling in their hands and feet, then no feeling, and it is not uncommon for toes, feet and even legs to require amputation because of injuries that became gangrenous, or terrible non-healing ulcers due to severly impaired circulation. Diabetics are at much higher risk for heart disease and strokes.

EXAMPLES:

Doris, age 45, weighed in at 317 lbs her first visit. Her sugar was 350. We got after her and she was willing to keep coming in for diet counselling, and eventually she lost 100 lbs. He sugars required only a small amount of medicine and she couldn't believe how good she felt.

Maggie worked as a domestic and was paid $1/hour. She weighed 278 at the time I first met her, and her sugar was 546. I had to hospitalize her, and we ended up having to put her on insulin. She tried real hard to pay attention to the diet instructions the nurses gave her in the hospital. One day, shortly after she was discharged, I had to run over to get something at the grocery store at lunch. There was Maggie, walking up and down the aisles, food stamps in hand, looking very puzzled. "What's going on,Maggie?" I asked. "I'se looking for them little naked taters like they give me in the hospital, and for them little oranges in the can, 'cause I knows I can eat them and my sugar won't mess up." Maggie lived about two miles out of town and her only meal was when she walked into town and got herself a hamburger. Her weight got down to 238; she pastes papers in the front of our new charts and in exchange we provide her insulin. She trades her food stamps sometimes for her syringes if she doesn't have any money.

EXAMPLES: (cont.)

Sarah, age 82, lives way out in the middle of nowhere. She weighs 216 and requires 90 units of long acting insulin and 30 units of short-acting daily. She lives with her alcoholic daughter, who supposedly draws up the right amount of insulin each day. Recently Sarah became very weak, and we found her sugar to be well over 400. Since she was also dehydrated,I hospitalized her, and she soon got back under control Then I found out her routine insulin given at home was not the usual dose, but had been cut down, as they couldn't afford to pay for five bottles of insulin a month. (She makes a little more than SSI and medicaid allow.)

Mary, at 240lbs, is a double amputee and now almost completely blind from her diabetes. Her sugars run in the high hundreds but I am reluctant to change her insulin dose because she just eats whatever her 76 year old husband fixes for her. And he can't always remember what she's supposed to eat.

James, age 29, is an insulin dependent diabetic. He is not overweight, but has a terrible time controlling his sugar because he is not able to work and doesn't get enough food stamps to cover his needs for a month. He has come in with a sugar of 806, still able to talk (I don't know why he's not comatose.) We have agreed to provide his insulin if he will come in to work around before he runs out. Recently he decided to go chop cotton. He landed in the hospital in ketoacidosis (could have died) because he took his insulin, went to work, but had no food.

Then there was Willie, age 29, who came in because he was sick to his stomach. Because he was over 200 lbs, he got a blood sugar test-he didn't know he had a sugar problem, and had never been to the doctor. And his sugar was 368. We put him on an IV in the clinic, got his sugar down to a more reasonable level, and sent him home to return the next day. Which he did, only he was also vomiting blood, having trouble breathing and was extremely ill.He was admitted with ketoacidosis, ended up having pneumonia, a bleeding ulcer and pancreatitis. Somehow he pulled through, and is now doing ok on insulin and diet. He and his wife both work, and for once there is no problem getting his medication.

PROBLEM: Respiratory problems

There are many of the obese patients in my practice who also have bad respiratory problems. Frequently this is due to lung disease, worsened by the fact that when the abdomen is obese, it pushes the diaphragm up when the person lies down, thus compressing the lungs and causing breathlessness. There is even a syndrome named for Mr. Pickwick from Dicken's writings, (the Pickwickian Syndrome) where the patient is breathless simply because of obesity. Poor oxygen intake impairs thinking processes and generally causes debility because the body can't function well.

PROBLEM: Hormone imbalance

More than one patient has complained of not being able to have children because of having no menses; this is most commonly due to obesity which distorts the balance of reproductive hormones.

There is also a constant high level of stress on the body by obesity, resulting in heightened production of hormones from the adrenal glands. One of these is the body's natural cortisone, which in high doses, depresses the immune system, making the obese person much more likely to become ill.

PROBLEM: Cachexia

This is a problem of a person who is much too thin, whose appetite is absent, who is constantly tired, depressed, frequently unable to hold a job from weakness. Depression is common, as is anemia and susceptibility to illness.

EXAMPLE:

Martha, age 37, weighs 86 lbs. She is trying to raise three children. Appetite pills have not helped increase her weight. She is constantly tired, frequently has headaches. When we have it, we give her cans of Ensure, a protein supplement. She doesn't feel she can get it, even though she could get it with food stamps, because there wouldn't be enough food for the children if she spent it on herself.

Many of my elderly patients are cachectic, weighing in the 80's and 90's and not because they have cancer. I wonder sometimes if this is a result of a lifetime of deprivation in favor of the children, and now their stomach is just too small to accept a big meal, even if they had it.

PROBLEM: Nutrition in infants and children

One of the intake questions for new pediatric patients in our clinic deals with the preparation of formula. In a surprising number of cases we find the formula is being "stretched"; that is, the baby, instead of getting one can of formula mixed with one can of water, is getting one of formula to two cans of water, or some arbitrary amount of formula mixed with water. Sometimes we catch this when the baby is very little and can prevent further mistakes; on other occasions it is not until the child is severely deprived that we see it.

Virtually no one breast feeds their baby. In some cases this is because it is not socially the "in" thing; but there are a number of babies born to teen moms, who themselves are poorly nourished, and cannot make good breast milk. Besides, when you can get free milk on the WIC program, and cereal and juices besides, why breast feed?

We have also lately come across several moms who have switched to evaporated milk because they have run out of formula. This can be disastrous as the chemical balance and calories in this form of milk are not what the baby needs.

Many infants brought in for diarrhea or colic in reality have been fed highly allergic foods too early. The American Academy of Pediatrics recommends that orange juice not be given until after age one year, yet the WIC program gives out orange juice at age 4 months. And in introducing other foods to a baby at about age 6 months, the recommendation is to give one food at a time for four days in a row to be sure there is no reaction to it, then the next food for 4 days, etc. You start with the yellow vegetables, then the green, the the fruits, finally proteins like meats. This regimen is virtually unheard of by my patients' moms.

EXAMPLES:

On a house call to Rosie, whose baby was 8 months, I found the child sitting quietly on the bare, splintered floor of the shack, eating bacon grease out of a can beside her.

Jayonta, now age 15 months, has been asked to come in weekly for weight checks. Each time we question his mama closely about what she feeds him. In spite of all our instructions, home health nursing visits, and intensive efforts to watch his intake, his weight is dropping to the tenth percentile for the third time since birth. He has been referred to a specialist, and may have to be taken from the mom. (A sibling had been removed from the home several years ago. The mom simply could not care for the child, who was born with multiple congenital defects.)

BARRIERS FACED BY MY PATIENTS IN EFFORTS TO ACCESS PUBLIC ASSISTANCE PROGRAMS

FOOD STAMPS

In Tallahatchie county the population is 17,158 or so (1980). There are two towns with populations over 1000: Tutwiler (1176) in the northwest corner, and Charleston, the county seat (2600) located in the eastern third of the county. The remainder of the people are in tiny hamlets or in lonely shacks on back roads. There is no public transportation. In order to sign up for food stamps, a person has to go to Charleston, 30 miles away from Tutwiler. Two trips are required before stamps may be put in the mail. In some cases, if a person is eligible for $10 worth of stamps, it isn't worth it, as it costs$10 or $12 for them to get transportation to the food stamp office.

In the cotton chopping season (late spring, summer) people who have been waiting all year for employment go off to the fields and earn minimum wage chopping from before dawn to as long as there is light. These jobs may last a few weeks or less. In all cases, their income must be reported to the food stamp office, which then notes they have money for food and their allotment is changed or stopped. The next month, there is no cotton to be chopped, there is no money, and there are no food stamps. So one must go back to the food stamp office, (for a price) re-submit an application, and wait another period of time for the stamps to come through.

In some cases it seems the assignment of the amount of food stamps is quite arbitrary:

(This information was obtained in the process of interviewing people to participate in the Box Project.)

5 people, income $300, no food stamps, pay $51/mo rent; also gas, lights, water.

8 people, 3 rooms, $378/mo food stamps, get $160 AFDC; pay $45/mo rent, also pays gas, lights, ater.

2 people, $147 in food stamps, $96 AFDC pay $30/mo rent; gas, lights, water.

4 people, $268 food stamps, $120 AFDC, $80/mo from a son in the army. They are ½ mile from their water source; use wood for fuel; pay lights and gas.

8 people living in 3 rooms, get $426 food stamps, $144 AFDC. Pay $15/mo rent, also lights. No gas or water.

3 people get $211 in food stamps, $120 AFDC, $44/mo ironing; pay lights, water.

1 elderly man gets $12 food stamps, $86 in SSI and $206 social security. He as to keep a car as his water source is over a mile away.

WIC PROGRAM

The WIC warehouse closest to us is down the road 7 miles. The major problem is transportation (from Tutwiler, by someone else's car it runs about $8 - $10 for a round trip).

Many families do not understand that this is a supplemental program, and they stretch the formula by diluting it improperly. If a family has to haul their water, or the water source is bad (as at Goose Pond where the water is brown) I will sometimes write a note to give them ready - to - feed formula. But this cannot be done in a hurry; one must wait for the next appointment.

If an infant or young child on WIC is growing rapidly the amount given out does not change, even though the needs of the child have changed.

If a person misses appointments (common in the Delta where one has no clock, where one's ride doesn't show up or one's car breaks down) they are dropped from the program.

One mother had to have a C-section at the birth of her child. I encountered her ten days after birth. Her baby had a bleeding navel. What we found out was that her water source was ½ mile from her shack, she had two old chlorox bottles to haul her water in, but she simply could not walk the distance and carry the water so soon after surgery. Her doctor in Clarksdale, 15 miles away, had not written a note that she was anemic and needed WIC for herself; she had no way to get to Clarksdale, no way to get to the WIC warehouse (10 miles away) no phone to call anyone, no money to pay someone to take her. Nor did she want to leave her newborn child in the shack with the 2 year old sibling while she tried to go off and get water in order to dilute the formula.

COMMODITIES

This program has been distributing honey, cheese, butter and dried milk. The announcment is made in the local newspaper and by word of mouth (It is the rare person among my patients who gets a paper) The distribution is done at two sites, Charleston and Sumner. It is relatively straight-forward; no forms to puzzle over, no delay except waiting in line.

If you have high blood pressure and your doctor is on you not to eat salt, how can you eat cheese, which is full of salt?

If you have diabetes and should not eat sugar, how can you eat honey?

If you have heart disease and shouldn't eat animal fat, you should not be eating butter.

If you have to haul your water, or have no refrigerator, you aren't going to be very enthusiastic about dried milk, which a lot of folks don't drink (especially children) because they don't care for the taste.

THE INFANT MORTALITY PROBLEM

IN MY SERVICE AREA

INFANT MORTALITY

The new figures for infant mortality, a five year study, show that Tallahatchie county is down from 23/1000 live births to 20/1000. When you look at the statistics for 1986, Tallahatchie county had the most infant deaths of any of the surrounding counties.

I have been called only twice to pronounce a baby dead in the past three years. In both cases there was no visible cause of death. In each case I called the coroner, and in each case, no autopsy was performed. I suspect the case of death is listed as "crib death" or "sudden infant death syndrome", which is a bad mistake, as it grossly distorts figures of a little-understood disease which in many cases is declared to be the cause of death when autopsy results show nothing else.

In one situation I suspect the baby had been inadvertantly suffocated. In the other, the baby was sleeping at the feet of a teenager who was supposedly caring for it while the mother was out enjoying Saturday night. The teen was asleep on the couch. When the mother came home and went to feed the baby, she reportedly found it dead. It had not been noticeably bruised and the teen denied it had fallen on the floor.

Three months ago my nurse came to get me from a treatment room to check a new patient. She was 6 weeks old, and had come in because her mama's cousin had come by the house in a car and the baby"wouldn't suck." When I saw the child,she was as limp as a noodle. Her eyes were glazed and her respirations barely visible. While my office called the hospital, We piled the mom, my nurse, the oxygen tank and the baby into the clinic jeep and I drove up to the hospital as fast as I could. On the way we questioned the mom. She had been in every day that week with an older sibling who had a bad bronchitis, and who had been getting aerosols to try to loosen up the mucus in his throat. This baby, however, had been quiet, but had gotten diarrhea, and then had vomitted. In reality, the baby had quietly dehydrated while the noisy sib got all the attention. On arriving at the hospital, the lab work showed a potassium of 8.8, not compatible with life, and sometimes seen when babies are fed undiluted formula. (This the mother denied.) The baby's heart stopped about 10 that night, and the pediatrician rode up to the children's hospital in Memphis (90 miles) in the ambulance. The helicopter couldn't come as it was too foggy. But the baby died in spite of all efforts to save her.

There are several third hand stories of moms with babies waiting to be signed in at emergency rooms who passively wait their turn, only to find the baby has died while they were waiting. They do not seem to realize the gravity of the situation, or do not feel able to get attention that they have an emergency that requires immediate treatment.

THE AVAILABILITY OF PRENATAL CARE

In Tallahatchie county there are two county health departments where prenatal care in given. One is in Charleston, the other in Sumner, which is 5 miles down the road from Tutwiler.

On many occasions a newly diagnosed pregnant woman is referred to the closest health department but an appointment is several weeks away. In a few cases, the patient has come in to our clinic for care because they had no room that day at the health department. On occasion, I have been told by the nurse they can't possibly take any more girls because they had over 70 (to be seen in one day).

The major problems with prenatal care are transportation and apathy. The only doctors delivering in the area are at the Women's Clinic in Clarksdale. No one delivers in Tallahatchie county any more. Clarksdale is 15 miles away, and prices range from $8-$12 for a ride with someone.

We are in the process of starting a prenatal program at our clinic to help ease the load on the health department. At the moment we are looking for some good patient education tapes (And having a hard time finding them). Medicaid does not cover the cost of pap smears, required at the first visit, nor does it cover the cost of a urine pregnancy test (much cheaper than blood tests). We have obtained some gift money to help cover the cost of the paps.

Once before we had a speaker for teen moms all lined up, got four girls to promise they would come; we made arrangements with the public library to use their meeting room, which has a screen in it, and we had even driven 5 miles out to a lonely shack to get an affirmative answer from the 16 year old that we could pick her up at 1pm the following day. What enthusiasm the librarian had was quickly squelched by the head dragon librarian in Charleston who coldly informed her that the library rules did not permit meetings in the library, not even educational meetings. Several phone calls later, I found that we couldn't meet in the Tutwiler Women's Club, another large building, because the girls invited were black, although the speaker was white. In desperation I called a former patient on the library board who said she was unable to get ahold of the person in charge (the dragon) and to go ahead and have the meeting but just this once. As it turned out, when we went to pick up the girl in the shack five miles out of town, the padlock was on the door and no one was home. One mom did turn up, with her mother, and so the speaker kindly did the whole program for those two, who were very enthusiastic and said they had learned a lot. The head librarian threatened to close the library if any more meetings were held, as it was completely contrary to the by-laws of the library, and came to personally sit in the library in Tutwiler the following Monday incase we dared to have a meeting. The problem has been solved by the fact that the town bridge was condemned and in order to get community development block grant money for the bridge, the town threw the clinic into the grant proposal and we now have a small meeting room in a wing on the back of the clinic for education.

One of the heartaches about pregnant teens is the terrible attitude in the schools. It takes an exceptional young woman to face the ridicule of teachers and students when she begins to show her pregnancy and tries to continue to attend school. Many girls simply don't finish, and may go years before trying to get their GED, if ever.

In other cases, if a pregnant mother has other little ones at home, she has no one to care for them when she comes to pre-natal care. Often she will bring the baby and sit there trying to entertain it while you are trying to instruct her.

[From People Magazine, March 1987]

SISTER ANNE BROOKS, DOCTOR AND NUN, PRACTICES WITHOUT PREACHING TO THE POOR

by Bill Shaw

Tutwiler, Miss. looks like photographs from the Depression: tin-roofed shacks, many with a scraggly dog and junked car in the muddy yard, and folks sitting on the porch not doing much of anything. Only problem is that it's now 1987, and Tutwiler still looks that way.

There's money to be made here, though, because Tallahatchie County's rich alluvial soil yields $40 million worth of cotton a year. But that bounty has escaped Tutwiler's 1,200 residents, almost three-quarters of whom are black. Per capita income here is less than $3,000 a year. Most folks are farm workers, or maids who work for minimum wage or less. For those who don't work, because of health or lack of opportunity, there are government checks. A mother on welfare with two children gets $120 a month from the state, plus food stamps (78 cents a meal). In Tutwiler, a gallon of milk costs $2.95 plus 6 percent sales tax.

For the past three years Tutwiler has also been the home of Anne Brooks, 48, a physician and Roman Catholic nun. She became a nun in 1955 at age 17. She was in a

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"People here never give up," says Sister Brooks (leaving after paying a house call to Mary Ann Willis, left). Above, she comforts another patient, Sarah Yarborough, who is a diabetic.

Photographs by Andy Levin

wheelchair for 17 years after that. She's only been a doctor for the last four years.

There was no doctor in Tutwiler for a decade before Sister Anne came in 1983. The last doctor got in his car one day, headed north on Highway 49 and never looked back at this battered Mississippi River delta town. During those years Tutwiler's residents had to drive 15 miles north to the next county to see a doctor, which meant they had to have a car that worked and money for gas. Most have neither.

Tutwiler is not a town that can do without a doctor. The infant mortality rate is 23 deaths per 1,000 births, more than twice the national average, and one-fifth of the babies born here are born to teenage mothers, twice the national average. Illiteracy, mental retardation, malnutrition and disease are rampant. Slop jars substitute for indoor plumbing in one out of every five homes. Hopson Bayou, which runs through the town, churns with raw sewage. When doctors visited Tutwiler and the rest of Tallahatchie County, they reported in the 1985 Harvard University Physician Task Force on Hunger in America: "We really saw people as close to the brink of survival as one is likely to find in this nation."

"It's not easy to get a doctor in rural Mississippi," says Ira A. Ousley, 55, president of Tutwiler's United Southern Bank and a 16-year veteran of the town council. "We sought to find a doctor," but he says no one answered the advertisements that the town council ran in medical publications. "We don't have a golf course and no place for a doctor's sailboat. Nobody has any money; all we had to offer was a lot of people who needed health care."

That is why Tutwiler's mayor, the late Johnny Jennings, could hardly believe the letter he received in 1983 from Anne Brooks. She wanted to come to Tutwiler. If that wasn't strange enough, this doctor was a woman and a Roman Catholic nun of the Sisters of the Holy Names of Jesus and Mary. "We thought it was a joke," says councilman Ousley, who, like practically everyone else in Tutwiler, is a Baptist. "We wondered if she'd try to build a church or something."

Sister Anne knew why she wanted the job: "I was looking for the bottom of the barrel, and Tutwiler is it."

The town jumped at her offer and turned over its abandoned health clinic

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Rosie Ham and her three children live in one room. "They survive against great odds," Brooks says of her patients.

Tutwiler's muddy back roads regularly snag Brooks's car, but her house calls are vital to patients who lack transportation.

to her. The first thing she did was remove the partition in the waiting room that separated blacks and whites. Says Ousley, probably one of the few bank presidents who mans his own drive-up window and sometimes sweeps the floors at night, "From day one, she's been a success." Dr. Brooks treats everyone from plantation owners to cotton choppers.

She made it clear that she was a healer, not a preacher or a missionary. "I'm not here to make anybody Catholic. The faith of these people is deeper than my own," she explains. "I get tied up in my work, and I don't think of God as much as I should. God travels with these people."

The clinic has no fixed budget. It just runs, mostly on donations and whatever patients can pay, which isn't much. Some patients pay with catfish and collard greens. Lillie Mae pays for her care by peeling the labels off prescription bottles so they can be reused.

Lue Bertha left a note stuck to the door: "I am going to pay. I just an't had no money but I a show going to pay your because if it was not for your I would be dead today."

Last year, the clinic had charges of $233,000 and collected $186,000, much of it from Medicare and Medicaid. "These are proud people. If they feel they have to pay immediately, they just won't come," says Dr. Brooks, whose fee is $15 a visit. "I want them to come when they need me." She herself receives $460 a month, and the five nuns who assist her earn salaries "paltry in comparison to what they'd make in a hospital or private clinic," she says. Sister Cora Lee Middleton, 44, and Sister Zenon D'Astous, 53, are registered nurses, and Sister Lorene Schuster, 51, is a medical assistant. Sister Rita D'Astous, 59 (Sister Zenon's real sibling), runs the lab, while Sister Madelyn Hogan, 67, handles all the insurance work.

In its three years the clinic has treated 23,000 patients with ailments ranging from AIDS to cancer to rat bites. The main problem, explains Sister Anne, is malnutrition and its side effects: diabetes, anemia, high blood pressure and depression. "I can't change centuries of social injustice and economic slavery, but I can cure sick people and that's my job here," she says.

When Sister Anne arrived there was no pharmacy in the town. She conferred with Frank Dong and Edward Woo, who ran the drugstore in nearby Webb, and convinced them to open the W & D Pharmacy in Tutwiler. "We couldn't lose nothing, 'cause Daddy owned the building," explains Dong. Woo's sister, Janet, says, "Dr. Brooks is the only thing helping this town. She helps people in ways she doesn't even talk about. She teaches people to read, and she's always doing little things like getting clothes for people or buying them food."

Patients come to the clinic during visiting hours, and after hours they come to the rented ($225-a-month) two-story house where the nuns live. On a recent Sunday a wheezing, rattling white Chrysler pulled up in front. A mother, holding her 18-month-old baby girl and trailed by three friends, came into the living room. The child had a distended stomach, a fever and diarrhea. "Her body's down," said the mother. "I think she has worms." Brooks gently put the child on the dining room table and began examining her.

"Has she had anything to eat today?" Brooks asked the mother.

"A little pop and some Fritos."

Brooks concluded the child just had the flu, suggested some Gatorade, wrote a prescription for an antibiotic and told the mother to stop by the next

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Brooks joins with coworkers for evening Mass. "Being a Catholic nun in a Baptist town," she says, "has raised no problems.

day. Later she said, "People eat terrible things because they have no money. I asked a patient with diabetes to write down what she ate for a week so I could monitor her diet. She had a Vienna cocktail sausage or a hot dog and white bread for every meal. When people don't have good nutrition, they can't think straight, don't do well in school, and the cycle of poverty continues."

Sister Anne soon discovered other problems: Women don't drink water before going out in the fields to chop cotton because there is no place to go to the bathroom and they're embarrassed, so they become dehydrated; some diabetes patients can't refrigerate their insulin because they have no electricity; and some patients have no tablespoons with which to measure medicine. "You see things here you see nowhere else. I guess we're doing a lot down here, but nothing ever seems to change. Maybe I've saved a few people from having their legs cut off from the effects of diabetes. The system crushes these people, and they are good and decent people. You can't help crying sometimes." When that happens, Sister Brooks says she cries herself to sleep while listening to Mozart, on a bed that is a board with a mattress balanced between cinder blocks. "It's funny," she says, "I don't pray for specific stuff anymore. The list is too long. I'd give the Lord too much work. My plea is that the Lord will just take care of us all."

A look at Anne Brooks's past helps explain why she has chosen to live and work in a place like Tutwiler. She was born in Washington, D.C. in 1938, the only child of an alcoholic mother and a Navy captain father. Her parents divorced when she was 10, and her father sent her off, although she was not Catholic, to a Catholic boarding school in Key West. "I decided at age 11 to become a nun. At the time I needed a lot of love and these women gave it to me," she says of the nuns at her school. "Their selflessness and dedication really hit me. I wanted to be like them." She took her final vows as a nun at age 24, seven years after she had been stricken with crippling rheumatoid arthritis. She was told then that she'd be on crutches or in a wheelchair the rest of her life. Nonetheless, she went to Barry University in Miami and graduated with a B.S. in elementary education. She began teaching at Catholic schools in Florida, and despite her handicap she worked in her free time as a volunteer at drug rehabilitation clinics, abused women centers and any place else where people needed help.

In 1972 she met Dr. John Upledger, founder of the St. Petersburg Free Clinic and an osteopath. A specialist in chronic pain, he began treating her arthritis using osteopathic manipulation of the joints and acupuncture. He also changed her diet, started her on an exercise program and urged her into psychotherapy to see if perhaps her arthritis was stress related. Six months later she was out of her wheelchair. "Living as a nun at that time was stressful," she says. "I was a sister with the habit. I always wore a veil. I had no identity as a person. I think my unhappy childhood and the subsequent repressed life I led probably contributed to the stress that caused the arthritis."

When Dr. Upledger moved to Lansing, Mich. in 1975 to become a professor of biomechanics at Michigan State University's College of Osteopathic Medicine, he kept in touch, urging her to come to Michigan to get a degree in osteopathic medicine. "She's real, the most honest person I've ever known," he says. In 1978, then 40, she finally heeded his advice. "I wanted to help people, like I was healed," she explains. A National Health Service Corps scholarship paid for her four years of study at the college on condition that she practice medicine in a medically deprived area for four years following graduation.

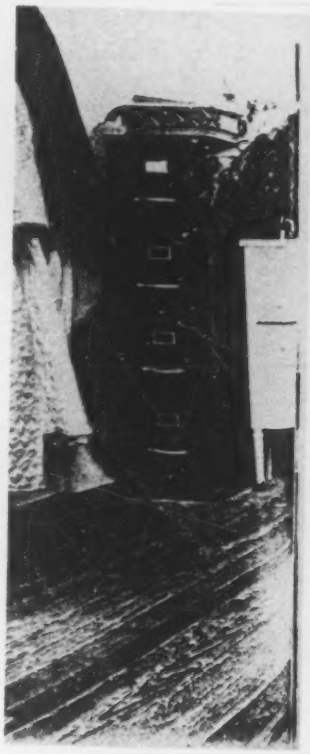
Her patients don't know too much about any of this. They just know that now she is in Tutwiler and that she cares about them.

Oudie Brown, 65, a retired railroad worker, broke both legs while crushing rocks a few years back. The legs healed, but the pain lingered. Recently, he stepped on a nail and it went clear through to the top of his foot. Now he's sitting in Dr. Brooks's waiting room. "I tell you something," he says. "I explain my thoughts to Dr. Brooks and she listens. She's never in no hurry. She takes my pain away."

Nannie Lee is 41, but she looks 61. She once jumped from a car traveling 60 mph because she was drunk and the man she was with made improper advances and she is a lady. She mangled her leg and was in a cast for six months and drank to ease the pain. When the cast came off, she says she started going around on her husband because he was going around on her. The courts took her children away because she was an alcoholic, and that made her drink even more. One day she went into the cotton fields to work and she thought Jesus was speaking to her, telling her to mend her ways. When Dr. Brooks came to town, she began counseling Nannie Lee. "My body was way down, but Dr. Brooks she treated me real good. She talked nice to me. She told me to be careful. And one day the Lord took the taste for alcohol out of my mouth," says Nannie Lee. "I don't drink no more."

Mary Lee, 46, is the mother of 11 children and a diabetic. She lives in a shack in the shadow of one of the few remaining antebellum mansions. Her roof is corrugated tin, her walls planks

"This is the time that I need for myself after



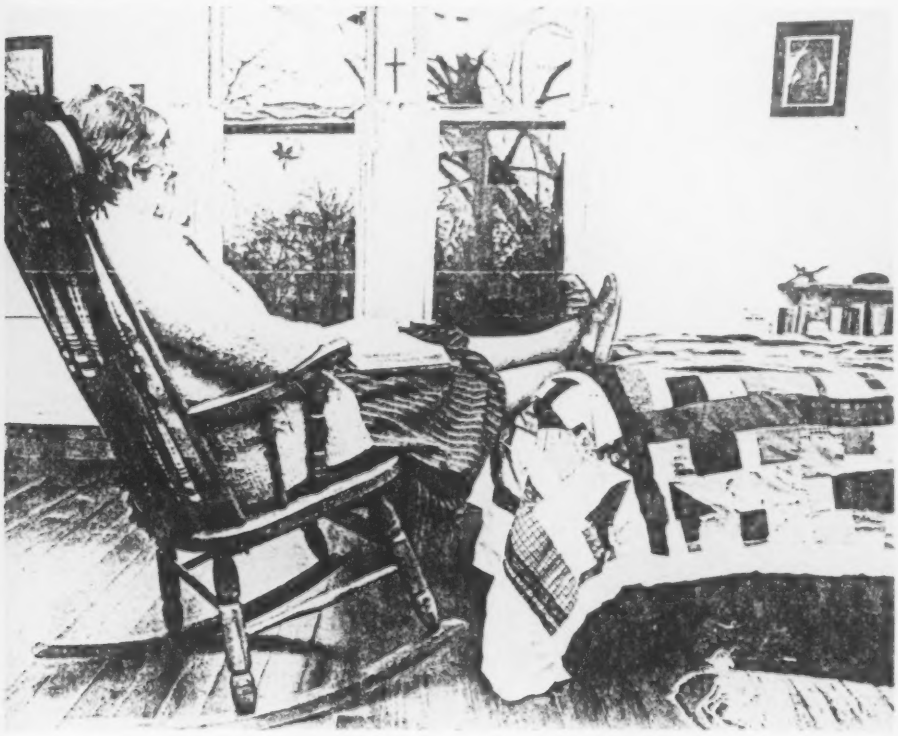
nailed together, and all of this is precariously balanced on cinder blocks. There's a wood-burning stove in the corner for heat but no running water. In the room is a bed, two overstuffed chairs and a color television set on which a commercial for Caribbean cruises is blaring away. Mary's husband, Leroy, stares at the advertisement while Frederick, their 2-year-old son, runs around barefoot. Up near the ceiling there is a crunching sound. It's a rat eating through the cardboard tacked up there to keep the wind out. When Dr. Brooks arrives, Mary Lee tells her how she has been feeling and that she's taking her insulin regularly.

Mary Lee is just one of Dr. Brooks's regular stops. She has put more than 91,000 miles on the odometer of her four-wheel-drive Wagoneer and seems to know something about every house and every person she passes on Tutwiler's rutted roads and overgrown paths. "The red house over there," she says, pointing, "I pronounced a baby dead. She weighed a pound. That's Richard's house over there. He's blind. A woman died in that barn up there. She was 37 and we don't know why. The county won't do autopsies because they cost $1,000. I found a man in that junk car over there."

Earlier this year she got up in the middle of the night and drove 15 miles to the Clarksdale Hospital and stayed with Mayor Jennings until he died. "It was good that I could care for him at the end and cheer him on, because that's what he did for me when I first came to this town," she says. The mayor was buried in his baseball cap. "He was looking good," she says.

In August Anne Brooks will have fulfilled her four-year obligation to the National Public Health Corps. She could leave Tutwiler then. She could go somewhere else, where people don't hurt as much and they eat better and they can pay their medical bills. But she won't be leaving, not this August, not next August, not ever. "This place has changed me so much. I'm less selfish; material things don't matter anymore. I've learned not to expect instant results. I learned that from the people here because one of the things poor people do is wait. They wait for everything: food stamps, the doctor, transportation, everything," she says. "I receive much more from these people than I could ever give them. I'll leave when they bury me." □

all the confusion at the clinic," explains Brooks, who meditates in her room at the end of each day.



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SOCIO-ECONOMIC AND HEALTH INDICATORS FOR MISSISSIPPI AND LEFLORE COUNTY 1984 AND 1986

POPULATION

	1980	Black	White	1984
MISSISSIPPI:	2,520,638	35.2%	64.1%	2,598,000 (estimate
% Rural	52.7%			n/a
% Elderly	11.5%	32.6%	67.1%	n/a
% under 18	32.2%			n/a
% Below Poverty	23.0%	44.4%	12.6%	n/a
% Below 125% Poverty	20.2%	55.4%	18.1%	31.4%
LEFLORE COUNTY:	41,525	59.1%	40.9%	42,200 (estimate)
% Rural	44.6%			40.7%
% Elderly	18.9%	51.5%	48.5%	13%
% Under 18	34.5%			n/a
% Below Poverty	18.9%	53.2%	9.6%	n/a
% Below 125% Poverty	39.9%	64.1%	14.1%	n/a

UNEMPLOYMENT	1984	1986
MISSISSIPPI	10.2%	11.7%
LEFLORE COUNTY	15.8%	14.3%

Source: Mississippi Research and Development Center, Jackson, MISS.

HEALTH STATISTICS

INFANT MORTALITY(Deaths per 1000 Live Births)

	1981-1985 AVERAGE	1982-1986 AVERAGE
MISSISSIPPI		
TOTAL:	14.8	14.2
White:	10.1	9.8
Non-White:	19.9	19.0
LEFLORE COUNTY		
TOTAL:	25.2	23.6
White:	18.6	15.7
Non-White:	27.8	26.8

LOW BIRTHWEIGHT (Weight 2500 Grams or Less Per 100 Live Births)

	1981	1982	1984	1985	1986*
MISSISSIPPI					
White:	N/A	N/A	6.1	5.9	6.0
Non-White:	N/A	N/A	11.7	12.0	11.6
TOTAL:	8.7	8.9	8.8	8.8	8.7
LEFLORE					
White:	N/A	N/A	6.5	9.4	4.5
Non White:	N/A	N/A	13.1	13.1	13.0
TOTAL:	11.1	12.0	11.0	12.03	10.64

* 1986 figures reflect data for weight under but not including 2500 grams.

Source: Department of Health, Vital Statistics, Jackson, Miss.

INCOME MAINTENANCE BENEFITS

	FY 1984 (June 83-July 84)	FY 1986 (June 85-July 86)
FOOD STAMP PROGRAM - MISSISSIPPI		
Caseload:		
avg. persons per month:	517,938	489,954
avg. households per month:	163,479	159,714
Average Monthly Benefit per household:	$134	$136
Maximum Benefit:	$199	$211
FOOD STAMP PROGRAM - LEFLORE COUNTY		
Caseload:		
avg. persons per month:	11,273	10,456
avg. households per month:	3,124	3,002
Average Monthly Benefit: per household:	$148.00	$151.00

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)-MISSISSIPPI	1984	1986
Caseload:	52,899	53,685
Avg. Monthly Benefits:		
per person:	$31.09	$38.18
per household:	$91.15	$111.40
Maximum Benefit:	$96	$120
AFDC-LEFLORE COUNTY		
Caseload:		
avg. persons per month:	1416	1381
avg. household per month:	4249	4308
Avg. Monthly Benefit		
per person:	$31.08	$37.74
per case:	$93.26	$117.75

COMBINED AFDC & FOOD STAMP PACKAGE (for a family of three)

1984	1986
$295	$331.00

Source: Welfare Department, Jackson, MISS.
Education and Public Welfare Dept., Congressional Research Service

SUPPLEMENTAL FEEDING PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)-MISSISSIPPI

	CY 1984	FY 1984	CY1986	FY 1986
Ave. Caseload per month:	85,473	85,074	89,975	91,587
Women	15,765	15,561	13,600	15,161
Infants:	23,538	23,499	24,548	24,507
Children:	46,170	46,064	51,827	51,919
Percent Eligible Served:	56%	56%	59%	60%

WIC PROGRAM-LEFLORE COUNTY

	CY 1984	FY 1984	CY 1986	FY 1986
Ave. Caseload per month:	2419	2465	2590	2711
Women:	261	232	334	357
Infants:	644	690	659	684
Children:	1514	1543	1597	1670
Percent Eligible Served:	67%	67%	72%	76%

WIC Monthly Food Packages for infants under 12 months of age contain 31 cans of infant formula, a 24 oz. box of cereal, and 64 ounces of infant juice. Women and children receive non-fat dry or evaporated milk, cheese, four 6 ounce packages of dry eggs, 36 ounces of cereal, six 46 ounce cans of juice, and either one pound of dry peas or beanx of one 18 ounce jar of peanut butter.

Source: WIC Administative Director; Jackson, MISS.

SCHOOL FEEDING PROGRAMS-MISSISSIPPI

1985 AVERAGES

	School Lunch (187.9 days)		School Breakfast (180.0 days)	
Ave. Daily Participation:				
TOTAL:	52,814		14,366	
REDUCED PRICE:	4,225	8%	718	5%
FREE:	33,272	63%	12,642	88%

SCHOOL FEEDING PROGRAM-LEFLORE COUNTY

	1984				1985-86 School Year			
	Lunch		Breakfast		Lunch		Breakfast	
Ave. Daily Participation								
TOTAL:	3717		1359		3769		1313	
REDUCED PRICE:	189	5%	28	2%	264	7%	4.5	82%
FREE:	3668	98%	1313	97%	3091	81%	1229	93.6

April 1987
(20 days)

	School Lunch		School Breakfast	
Ave. Daily Participation				
TOTAL:	3711		1355	
REDUCED PRICE:	219	5.9%	54	4%
FREE:	3080	83%	1274	94%

SOURCE: Department of Education, Jackson, MISS.

Elderly Nutrition Programs

E.N.P-MISSISSIPPI

	1984		1986	
	Congregate	Home Delivered	Congregate	Home Delivered
Avg. Participants per day:	8138	3721	7508	4862
Avg. Total:	11,859		12,370	

E.N.P.-LEFLORE COUNTY

	1984		1986	
	Congregate	Home Delivered	Congregate	Home delivered
Avg. Participants per day:	183	45	180.1	60.4
Avg. Total:	228		240.5	

Funding for 1986 Leflore County congregate meal programs is received from Title 3-C1. Funding for Home Delivered Meal programs is received from title 3-C2 and Title XX. 1986-87 funding for Home Delivered Meal programs was also suppemented by Special Initiative Funds that will not be available in 1988.

Emergency Food Assistance

MISSISSIPPI FOOD BANK

	Jan.-Oct. 1983	1986
LEFLORE COUNTY		
Ave. Number of Families Served:	308	50
Ave. Number of Persons Served:	1811	210

Private donations were the primary source of 1986 funding for Mississippi's Emergency Food Assisstance. Donors included the Food Bank's 125 member agencies, and such organizations as USA for Africa. Remaining revenue is supplied through fundraising. Food is distributed through the Food Bank's two distribution centers in the Jackson area. The closest to Leflore County is located in Greenville, Miss., 40 miles outside Greenwood.

MEDICAID

Mississippi's Medicaid program covers all AFDC children and their mothers. Mississippi is among the states that have elected to implement the new Medicaid eligibility requirements allowed under the 1986 Omnibus Budget Reconciliation Act. Effective October 1987, Mississippi will raise its needs standard for pregnant women and for children under one year of age, thereby extending medical coverage to a projected number of over 12,000 women and children in 1987. Children up to age five will be phased in year by year after the initial start-up of the program.

Prepared Statement of Emma Brown, Yazoo City, MS

Thank you for allowing me this opportunity to tell you about me, my family and my experience with the food stamp program. I am 65 years of age and receive $58.00 per month in SSI. I live in subsidized housing in Yazoo City, Mississippi. My two sons and grandson live with me. My sons are: Larry Brown and Charles Sanders: my grandson is Reginald Brown. Larry is 23 years old and Charles is 21 years old. Neither my sons, nor my grandson get any assistance from their fathers. My son, Larry, makes $40.00 per month cleaning up the Credit Bureau office in Yazoo City.

My son, Charles, attends Jackson State University in Jackson, Mississippi. My grandson, Reginald Brown, attends Alcorn State University in Lorman, Mississippi. My son, Larry Brown, does not attend school and has not been able to find a regular job or be placed in any training program. He continues to go to the employment office looking for something to help him but he is always told there is nothing.

I receive $92.00 per month in food stamps. The stamps are a help, but they are only for me and my son, Larry. My worker told me that I could not get stamps for Charles and Reginald because they go to college. I explained that even though they go to college, they come home on the weekends.She said they still could not be put in my food stamp budget. She even told me that I did not need to let Charles come back in my household. I asked her, "How could I not let my own child come back to my house, when he doesn't even have a job or a place to go?"

It is very difficult to make ends meet, when you only have a total of $398.00 to live on. I am a diabetic and the food I have to eat is very expensive and I have to buy some of my medicine because Medicaid won't pay for it. You see, I have to pay: rent - $65.00, lights - $91.00, medicine - 28.00, burial insurance - $5.60, personal items - $25.00, and groceries - $150.00 per month. After paying my bills and trying to feed myself and my children, I don't have much of anything. If any of my bills go up, I don't know how I am going to make it.

It is all confusing because all you hear is that your children need to get an education so they can help themselves. Then when your children try to get that education you lose some of the help you could get. For example, if my son, Charles, and my grandson, Reginald, were not trying to go to college, but were at home looking for work, (of which there is none), everyday, I could get food stamps for them. If my children could get some help while going to school, they are more likely to get jobs when they finish, which seems to me, would mean they could put more money into the government because of the taxes they would be paying. The way it is now, the only way they could get food stamps would be for them to quit college and join the long line of unemployed people and cost the government more money for a longer period.

THE COMMISSIONER OF SOCIAL SECURITY
BALTIMORE, MARYLAND 21235

AUG 28 1987

Refer to
SEP72

Honorable Mickey Leland
Chairman, Select Committee
on Hunger
Room 507, House Annex #2
Washington, D.C. 20515

Dear Mr. Chairman

This is in response to questions about supplemental security income (SSI) that arose during a recent discussion with a member of our Congressional Relations Staff.

SSI payments are not the same as Social Security benefits. Social Security retirement, survivors, and disability insurance benefits are financed primarily from taxes paid by workers and their employers. Social Security benefits are paid to eligible workers and their families regardless of the amount of their resources and income other than earnings. The SSI program, on the other hand, is financed from general revenues, and because it is a program for the needy, eligibility depends largely on the applicant's income and resources.

A husband and wife who live together normally share their income. Therefore, when one of them applies for SSI, part of the other's income must be counted as though it were the applicant's.

On the other hand, it is not equitable to count the income of one spouse in determining the eligibility of the other when they do not share the same living arrangements. Therefore, if a couple is separated and they do not share incomes, each is treated separately for SSI eligibility. This should in no way be taken as a suggestion that a couple should separate to gain this benefit and certainly should not result in a person being placed in a nursing home where the circumstances would otherwise deem it inappropriate. The history of the SSI program clearly

indicates that the policy resulted from hardships created when couples were forced to live apart for other reasons and not to encourage separation merely for SSI eligibility purposes.

We hope this information is helpful to you.

Sincerely,

Dorcas R. Hardy
Commissioner
of Social Security

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